Proposed changes to the text of the following regulations and Hospital Manual pages are in a format where additions are in *italics* and deletions are in ~~strike out~~.

California Code of Regulations, Title 22

97018. Accounting and Reporting Manual for California Hospitals.

(a) To assure uniformity of accounting and reporting procedures among California hospitals, the Office shall publish an "Accounting and Reporting Manual for California Hospitals," which shall be supplemental to the system adopted by this Chapter. The "Accounting and Reporting Manual for California Hospitals," *Second Edition,* as amended ~~December 5, 1996~~, *(30 days after filing with the Secretary of State)* _____, ~~shall be known as the Second Edition of the hospital manual. The hospital manual~~ shall not be published in full in the California Code of Regulations, but is hereby incorporated by reference. ~~For fiscal years beginning January 1, 1992 and thereafter, all~~ *All* hospitals must comply with systems and procedures detailed in the ~~Second Edition of the~~ hospital manual. Copies of the "Accounting and Reporting Manual for California Hospitals" may be obtained from the Office at 818 K Street, Room 400, Sacramento, CA 95814. The Office shall provide each new hospital with a copy of the hospital manual. The hospital manual published by the Office shall be the official and binding interpretations of accounting and reporting treatment within the hospital accounting and reporting system.

(b) Requests for modifications to the accounting and reporting systems as set forth by the hospital manual shall be filed as provided under Section 97050.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97041. Report Procedure.

(a) Health facilities shall report to the Office on forms or other media prescribed by the Office.

(1) ~~Effective for reporting periods ending on or after June 30, 1994, health~~ *Health* facilities shall file the annual reports required by subsections (a) through (e) of Section 128735, Health and Safety Code, with the Office in a standard electronic format as approved by the Office pursuant to Subsection (4). Health facilities may file requests for modifications to this reporting requirement, as provided under Section 97050, where meeting this requirement would not be cost-effective for the facility.

(2) ~~Effective for reporting periods ending on or after March 31, 1994, hospitals~~ *Hospitals* shall file the quarterly reports required by Section 128740, Health and Safety Code, with the Office in a standard electronic format using the electronic reporting program (Hospital Quarterly Reporting System software, Version ~~1.1~~ *1.4*) provided by the Office. Hospitals may file requests for modifications to this reporting requirement, as provided under Section 97050, where meeting this requirement would not be cost-effective for the hospital.

(3) To meet the requirement of subsection (1), health facilities shall use a program approved pursuant to subsection (4), which can be either a third-party program or their own program.

Health facilities intending to use a third-party program are not required to notify the Office of that intent. The Office shall notify all health facilities and third parties with Office-approved electronic reporting programs of any change in the electronic reporting requirements. The Office shall maintain and make available a list of all programs approved pursuant to subsection (4).

(4) Programs to be used for filing reports in a standard electronic format pursuant to subsection (1) must be approved by the Office in advance and must meet the Office's specifications for electronic reporting, including dial-up via personal computer and personal computer diskettes. To be approved, electronic reporting programs must be able to apply Office-specified edits to the data being reported and must be able to produce a standardized output file that meets the Office's specified electronic formats. Specifications for submitting hospital annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements as published by the Office ~~on November 19, 1992~~ in the *July 1997 issue of* "Instructions and Specifications for ~~Submission of~~ *Developing Approved Software to Submit* the California Hospital Disclosure Report on Personal Computer Diskette," and herein incorporated by reference in its entirety. Specifications for submitting LTC facility annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements, as published by the Office ~~on October 30, 1992~~ in the *November 1997 issue of* "Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 1/4" or 3 ½" IBM PC Compatible Diskette," and herein incorporated by reference in its entirety. To obtain approval for an electronic reporting program, a request, together with the Office's specified test case and a signed statement certifying that the program includes all Office-specified edits, must be filed with the Office at 818 K Street, Room 400, Sacramento, CA 95814, at least 90 days prior to the end of the reporting period to which the program applies. The Office shall review the test case and respond within 60 days by either approving or disapproving the request. The Office may limit the approval of the electronic reporting program to a specified period of time or reporting period(s). If disapproved, the Office shall set forth the basis for a denial. The Office may seek additional information from the requestor in evaluating the request. Changes to the Office's electronic reporting specifications may require the programs used for filing reports in a standard electronic format to be re-approved.

(b) The Office shall develop forms and instructions related to their use, and related specifications for filing reports in an electronic format, and make such administrative revisions to the above items as may be necessary to assure uniform and appropriate reporting.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128680, 128730, 128735 and 128740, Health and Safety Code.

ACCOUNTING PRINCIPLES AND CONCEPTS

(B) The deduction from revenue (contractual adjustments) is calculated as follows:

	ACCOUNTING RECORDS	TAX/COST REPORT
Medicare Revenue ($180 X 50%)	$90	$90
Reimbursable Costs:		
$120 X 50%	60	
$130 X 50%	—	65
Contractual Adjustment	$30	$25

Of the $30 contractual adjustment for accounting purposes, $25 is the current portion and $5 is the deferred portion. The journal entry to record this expense is:

Dr.	Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*)	$30	
Cr.	Allowance for Contractual Adjustments - Medicare ~~Inpatient~~ - *Traditional* (Account 1042.00)		$25
Cr.	Deferred Revenue - Medicare Reimbursement (Account 2121.00)		$ 5

ACCOUNTING FOR PAYROLL COSTS 1115

Natural account classifications for salaries and wages and employee benefits must be maintained to complete the disclosure report pages 21 and 22, "Detail of Direct Payroll Costs."

For reporting purposes to the Office, salaries and wages include all remunerations paid in cash by the hospital to its employees for the actual hours worked. The actual hours worked are productive hours which must equal total hours paid less the hours not on the job.

Non-productive hours are to be accounted as employee benefits (sub-account number .12). Non-productive hours are hours not on the job such as vacation time, sick leave, holidays, and other paid time off. However, paid time spent attending meetings and educational activities at or away from the hospital is productive time and is to be accounted for under salaries and wages.

The disclosure report pages 21 and 22, "Detail of Direct Payroll Costs," are used to report the productive and non-productive hours. They are also used to report the average hourly rate by employee classification and cost center. Therefore, the following information is needed by employee classification and cost center:

ACCOUNTING PRINCIPLES AND CONCEPTS

PHYSICIAN BILLING SERVICES 1193

Many hospitals are providing billing services for physicians under an agency arrangement. Any fees charged the physicians must be recorded as Other Operating Revenue (Account 5780). Refer to Section 1191, Financial Arrangements, number 5 for further explanation.

ACCOUNTING FOR MEDICARE REIMBURSEMENT 1200

With the implementation of the Prospective Payment System (PPS), hospitals are now being paid a prospectively determined rate for each Medicare patient discharged from the hospital rather than being cost reimbursed.

Medicare reimburses hospitals using a variety of different methodologies depending on the services provided. The Prospective Payment System (PPS) was developed to reimburse for inpatient acute services based on Diagnostic Related Groupings (DRG's). Outpatient services are cost reimbursed subject to certain limitations for laboratory, radiology, and ambulatory surgery. Reimbursement for exempt units and Skilled Nursing Facilities are cost reimbursed subject to certain cost limitations.

Deductions from revenue arise as a result of the hospital's agreement to accept an amount less than gross charges as payment in full from Medicare. This reimbursement is made up of two components: the patient liability (deductibles and coinsurance) and the program liability. The contractual adjustment is the difference between gross reimbursement and gross charges. Any patient liability not collected is a bad debt, which Medicare will reimburse for if the appropriate collection proceedings have been performed. If the hospital has created a program where it waives the patient's responsibility for deductibles and coinsurance, these amounts must be written off as Administrative Adjustments (Account 5940).

Accounts receivable for Medicare patients must be written down to the net amount receivable from Medicare and the patient (deductibles, coinsurance, and non-covered charges) as soon as that amount is determinable. This may be at the point of billing or at the point of payment depending on the information available to the hospital. A reserve is required for any receivables that have not been written down as of year end.

Example journal entries for hospitals not on PIP (Periodic Interim Payments)

To record patient care services rendered:

Dr.	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional* (Account 1022.00)	$500	
Cr.	Revenue (Various Accounts)		$500

ACCOUNTING PRINCIPLES AND CONCEPTS

To record contractual adjustments

Dr.	Contractual Adjustments - Medicare - *Traditional* (Account ~~5810.00~~ *5811.00*)	$100	
Cr.	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional* (Account 1022.00)		$100

To record payment from intermediary

Dr.	General Checking Accounts (Account 1001.00)	$350	
Cr.	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional* (Account 1022.00)		$350

The above example assumes there is a $50 deductible due from the patient.

To record payment from the patient

Dr.	General Checking Accounts (Account 1001.00)	$50	
Cr.	Inpatient Receivables - Medicare (Account 1022.00)		$50

For cases involving cost settlement, the patient receivable must be reduced to reflect the interim payment rate and the contractual adjustment account is to be adjusted at year end (or quarterly) based on the expected cost report settlement.

Capital pass through payments and prior year cost settlement adjustments must be recorded in sub-accounts of Medicare Contractual Adjustments (i.e. ~~5811~~, ~~5812~~, *5813*, *5814*, etc.). They should be combined with 5810 for reporting purposes.

Medicare utilizes two inpatient reimbursement methodologies. The most common is a claim by claim basis. The above journal entries would be adequate for hospitals subject to this type of reimbursement. The second methodology is Periodic Interim Payments (PIP). Under this method of interim reimbursement the hospital receives a check for a fixed amount every two weeks regardless of the number of Medicare patients treated. The rate is updated on a periodic basis by the Medicare intermediary. As of July 1, 1987 the only hospitals remaining on PIP were those considered to be sole community providers or those having a 5.1 percent disproportionate share.

The recommended method of accounting for PIP is to credit Medicare PIP clearing (Account ~~1026~~ *1027*) when cash is received. The PIP clearing account would be debited when the patient receivable is billed to Medicare. Receivables that have not been billed but are included in the current year cost report should be written off to the PIP clearing account. At year-end when the cost report settlement is made, the account must be reconciled to a zero balance. Any difference in the account must be written off to the contractual adjustment account.

ACCOUNTING PRINCIPLES AND CONCEPTS

Example journal entries for a hospital that had total PIP receipts of $200,000, total Medicare charges of $400,000 and related DRG reimbursement of $250,000. Of the total charges $100,000 were unbilled at year-end with DRG payments of $50,000:

To record PIP receipts

Dr.	General Checking Accounts (Account 1001.00)	$200,000	
Cr.	Medicare PIP - Clearing (Account ~~1026.00~~ *1027.00*)		$200,000

When billing accounts receivable

Dr.	Medicare PIP - Clearing (Account ~~1026.00~~ *1027.00*)	$200,000	
Dr.	Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*)	$100,000	
Cr.	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional* (Account 1022.00)		$300,000

At year-end:

To clear out the unbilled Accounts Receivable

Dr.	Medicare PIP - Clearing (Account ~~1026.00~~ *1027.00*)	$50,000	
Dr.	Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*)	$50,000	
Cr.	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional* (Account 1022.00)		$100,000

To record cost settlement

Dr.	Other Receivables - Third-Party Cost Report Settlements - Medicare (Account 1051.00)	$50,000	
Cr.	Medicare PIP - Clearing (Account 1026.00)		$50,000

Note that the above example was simplistic and ignored capital pass through and deductibles and coinsurance both of which would be treated as noted in the first example. The balance remaining in accounts receivable at year-end would be the patient liability which includes deductibles, coinsurance, and non-covered charges.

ACCOUNTING PRINCIPLES AND CONCEPTS

With the implementation of the Prospective Payment System, hospitals are now being paid a prospectively determined rate for each Medicare patient discharged from the hospital rather than being reimbursed for reasonable costs. Even with this change, nothing really changed in the way Medicare gross and net revenue are calculated. Gross Medicare revenue is based on charges, net revenue is the amount paid or to be paid by all payors, and contractual adjustments are the differences.

Some hospitals under the Medicare prospective payment system (PPS) receive bi-weekly PIP amounts. These amounts are for both inpatient prospective payments and inpatient cost-based reimbursement amounts, including capital-related costs (primarily depreciation, interest, and lease payments), indirect approved medical education costs, and bad debts of Medicare inpatients for uncollectible deductibles and coinsurance. The entries to record PIP amounts are shown previously in this Section.

Logging System 1200.1

It is recommended that the hospital maintain a logging system for each of its contract payor types (Medicare, Medi-Cal, HMO/PPO's) only through logs can a hospital adequately track activity for the various contract payor types. For each patient logged the system should record the following items:

1. Total Billed Charges
2. Patient *(Census)* Days by Licensed Unit (ICU, CCU, Med/Surg)
3. Deductibles and Coinsurance
4. Outliers (Medicare) Amount
5. Expected Payment Amount
6. Actual Payment Received
7. Patient Account Number

OUTLIER PAYMENTS 1201

Under PPS, Medicare provides additional reimbursement for outliers. (The following assumes that these amounts are not included in the bi-weekly PIP payments.) Outliers are DRG cases with unusually long lengths of stay or unusually high costs. Length of stay outliers are paid automatically by the fiscal intermediary whereas payment for cost outliers must be requested by the hospital. If the hospital is able to identify outliers, it should establish an asset account, Outlier Payments Due from Medicare (Account 1054) to record additional outlier payments due. The hospital-determined outlier payment amount would be debited to Outlier Payments Due from Medicare (Account 1054) and credited to Contractual Adjustments - Medicare *Traditional* (Account ~~5810~~ *5811*). (The credit to the Contractual Adjustments account is correct because a debit was made to this account when the non-outlier DRG payments were processed. As a result, the Contractual Adjustments - Medicare account is overstated by the amount of the outlier payment.) When the outlier payment is received, the hospital will debit General Checking Accounts (Account 1001.00) and credit Outlier Payments Due from Medicare (Account 1054).

ACCOUNTING PRINCIPLES AND CONCEPTS

If the hospital is not able to identify DRG's, it is also not able to identify length of stay outliers. When a patient's bill is submitted by the hospital, the intermediary will process the bill for both the non-outlier and outlier payments. When payment is received, the hospital will debit Cash for the outlier DRG payments, debit Medicare PIP Clearing (Account ~~1026~~ *1027*) for the non-outlier DRG payment, debit Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*) for the excess of patient charges less non-covered charges, deductibles, and coinsurance over the non-outlier and outlier DRG payments, and credit ~~Inpatient~~ *Patient* Receivables - Unbilled (Account 1021).

If the hospital is not able to identify cost outliers, the intermediary will process the bill as a non-outlier bill. The hospital may then submit an adjusted bill for the outlier portion, if medical necessity has been approved by the medical review entity. In this case, the hospital would initially debit Medicare PIP Clearing (Account ~~1026~~ *1027*) the non-outlier payment, debit ~~Inpatient~~ *Patient* Receivables - Other (Account ~~1025~~ *1026*) for non-covered charges, deductibles and coinsurance, debit Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*) account for the excess of patient charges less non covered charges, deductibles and coinsurance over the non-outlier payment, and credit ~~Inpatient~~ *Patient* Receivables - Unbilled (Account 1021). As a result, the Contractual Adjustments account is overstated for the outlier payment due. Therefore, the hospital will debit General Checking Accounts (Account 1001.00) and credit the Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*) account to correct the overstatement when the outlier payment is received.

COST BASED REIMBURSEMENT 1202

Under the Medicare Program services performed for Outpatient, Drug Rehabilitation, Psychiatric and Home Health are reimbursed based on costs subject to limitations on cost. On an interim basis the hospital receives a percentage of charges or per diem as reimbursement. At year-end the cost report is prepared; the actual cost related to those services is determined and final settlement is made.

Accounts receivable for Medicare patients must be written down to the amounts receivable from Medicare on an interim payment basis, and the patient (deductibles, coinsurance, and non-covered charges) as soon as that amount is determinable. This may be at the point of billing or at the point of payment depending on the information available to the hospital. The contractual adjustment amount will also need to be adjusted based on any program reimbursement subject to cost limitation through the cost report. A reserve is required for any receivables that have not been written down as of year-end.

Example journal entries under cost based reimbursement are as follows:

To record patient care services rendered:

Dr.	~~Outpatient~~ *Patient* Receivables - Medicare (Account ~~1032.00~~ *1022.00*)	$100	
Cr.	Revenue (Various accounts)		$100

ACCOUNTING PRINCIPLES AND CONCEPTS

To record interim payment from intermediary:

Dr.	General Checking Accounts (Account 1001.00)	$40	
Cr.	~~Outpatient~~ *Patient* Receivables - Medicare (Account ~~1032.00~~ *1022.00*)		$40

(Assume $20 deductible and coinsurance and Medicare pays $40 on an interim basis.)

To record contractual adjustment:

Dr.	Contractual Adjustments - Medicare - *Traditional* (Account ~~5810~~ *5811*)	$40	
Cr.	~~Outpatient~~ *Patient* Receivables - Medicare (Account ~~1032.00~~ *1022.00*)		$40

To record payment from patient:

Dr.	General Checking Accounts (Account 1001.00)	$20	
Cr.	~~Outpatient~~ *Patient* Receivables - Medicare (Account ~~1032.00~~ *1022.00*)		$20

The Contractual Adjustment Account (Account ~~5810~~ *5811*) is to be adjusted at year-end (or quarterly) based on expected cost report settlement.

YEAR-END CLOSING 1203

At year-end there will be Medicare patients which have been discharged but the fiscal intermediary has not been billed. Appropriate entries must be made to account for revenue earned relative to such patients.

Also, at year-end there will be Medicare patients who remain in the hospital. In order to match the revenue and expense, DRG revenue must be allocated between accounting periods. This can be done based on patient (census) days (using the hospital's patient day experience or the HCFA mean length of stay) or patient charges.

Using the hospital's patient charge experience, and assuming that the hospital can determine the DRG for each patient, the revenue allocation formula would be as follows:

$$\frac{\text{Patient Charges Incurred through Year-End}}{\text{Total Patient Charges upon Discharge}} \times \text{DRG Payment} = \text{Allocated Current Period DRG Revenue}$$

ACCOUNTING PRINCIPLES AND CONCEPTS

Reinsurance (also known as: Stop-loss insurance) - A contract in which an insurance company agrees to indemnify the contracting hospital for certain health care costs exceeding a predetermined amount (limit) incurred by the contracting hospital in providing care to members. The limit usually covers an annual period and is applied against accumulated charges, a percentage of charges, or patient days for all episodes of care rather than being applied to each episode of care.

Subscriber - The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in the HMO.

Contracting hospitals normally contract to provide all covered inpatient services and specified outpatient services required by HMO members even if all services cannot be directly provided by the hospital. If certain services cannot be provided on-site, the contracting hospital must purchase such services from other hospitals.

The most common contracts fit into the following three categories:

1. Per Diem - This is a contract with an agency to accept a fixed amount per patient day. The most common example of this is the Medi-Cal contract that hospitals enter into with the State of California. In accounting for these transactions the hospital would make the following entries:

   Assume a patient is treated that belongs to XYZ HMO. XYZ has a contract with the hospital to provide care at a rate of $500 per day. The patient is in the hospital for 3 days and generates charges at the hospitals normal rate totaling $4,000.

   To record the receivable

Dr.	~~Inpatient~~ *Patient* Receivables - Other *Third Parties - Managed Care* (Account ~~1026.00~~ *1035.00*)	$4,000	
Cr.	Various revenue accounts		$4,000

   To recognize the contractual adjustment

Dr.	Contractual Adjustments - Other *Third Parties - Managed Care* (Account ~~5850~~ *5852*)	$2,500	
Cr.	~~Inpatient~~ *Patient* Receivables - Other *Third Parties - Managed Care* (Account ~~1026.00~~ *1035.00*)		$2,500

   Calculated as $4,000 less $1,500 (Total per diem = 3 days times $500 per day)

ACCOUNTING PRINCIPLES AND CONCEPTS

When payment is received

Dr.	General Checking Accounts (Account 1001.00)	$1,500	
Cr.	~~Inpatient~~ *Patient* Receivables - Other *Third Parties - Managed Care* (Account ~~1026.00~~ *1035.00*)		$1,500

Note that the receivable may be written down at the point of billing or at the time payment is received. It is important to be sure and reserve in the Allowance for Contractual Adjustments - ~~HMO/PPO~~ *Other Third Parties - Managed Care* (~~Accounts 1047.00 or~~ *Account* 1048.00) for amounts in accounts receivable that have yet to be written down to the contracted amount.

2. Risk Sharing Contract - In this type of contract, the hospital agrees to absorb a portion of the cost of treating the particular HMO's patients if the expense incurred during the year exceeds the previously agreed upon budgetary limits. At the same time, the hospital will share in the profit if the expense is under the previously agreed upon budgetary limits. This creates incentive for the hospital to treat each patient as efficiently as possible. Patients treated under these types of arrangements are accounted for in the same manner as noted above. The only difference is that at year end there will be a liability to or a receivable from the HMO for the difference between actual cost and budgeted cost. On the balance sheet the entry will be recorded in either Other Receivables - Third-Party Cost Report Settlement-Other (Account 1053.00) or in Reimbursement Settlement Due - Other Third-Party Payors (Account 2063.00). The other side of the entry creating this receivable/liability must be ~~to~~ recorded in ~~the Contractual Adjustments HMO/PPO and Other Contracts~~ *Capitation Premium Revenue - Other Third Parties* (Account ~~5840~~ *5990*).

3. Capitation Contract - Under this arrangement, the hospital agrees to treat the members of the health plan for a fixed rate per member per month. The hospital is at risk and is liable for any expenses incurred beyond the monthly capitation payments. Under certain circumstances, an HMO may remit payments in advance to hospitals for services not yet identified. Situations such as this should be accounted for similarly to the accounting for capitated contracts. Hospitals may purchase what is termed reinsurance which will indemnify the hospital for any patient whose charges exceed a flat amount.

INPATIENT SERVICES 1221

For inpatient services that are provided by the contracting hospital within its own facilities, the accounting of the revenue and expenses for capitation patients is no different than that for any other patient. Revenue (recorded at full-established rates) and all direct expenses, as defined in this Manual, must be accounted in the functional centers related to the services provided. However, for inpatient services (other than just ancillary services) which must be obtained from another hospital where the member is admitted to the other hospital, the accounting for the related revenue and expenses must be accommodated in a different manner.

ACCOUNTING PRINCIPLES AND CONCEPTS

The following are four situations in which inpatient services are provided to members:

1. A member is admitted to the contracting hospital and all daily and ancillary services are directly provided by that hospital. The gross revenue, expenses, and units of service are recorded in the functional centers related to the services provided.

2. A member is admitted to the contracting hospital and most, but not all, ancillary services are directly provided by that hospital. For example, although the patient remains an inpatient of the contracting hospital, the contracting hospital must purchase computed tomographic scanner services from another hospital or organization. In this case, the gross revenue, expenses, and units of service related to all purchased ancillary services must be recorded by the contracting hospital in the functional centers related to the services provided even though purchased from another hospital.

3. A member is not admitted to the contracting hospital but is admitted to another hospital (or to a skilled nursing or intermediate care facility which is not operating under the license of the contracting hospital) with the approval of the contracting hospital. Since the contracting hospital is responsible for all of the cost of the services provided by the admitting hospital, the admitting hospital will bill the contracting hospital for the care provided. Because the member was not admitted to the contracting hospital, it is inappropriate to record the expenses and related units of service [patient (census) days, surgery minutes, etc.] in the functional cost centers of the contracting hospital. It is also inappropriate to gross up the revenue of the contracting hospital related to the services provided by the admitting hospital. However, since the contracting hospital is responsible for the cost of the services provided and has received capitation fees to provide all inpatient services, such cost must be recorded as patient service expense. ~~The related revenue must be recorded as patient service revenue as discussed below.~~

4. A member is first admitted to the contracting hospital but during the same episode of care is transferred and admitted to another hospital, or vice versa. In this case, the services provided by the contracting hospital would be accounted as described in 1 or 2 above and the inpatient services provided by the other hospital would be accounted as described in 3 above.

Because the capitation fees are not related to specific patients, all earned capitation fees must be recorded as a credit to ~~Contractual Adjustments - Other (Account 5850)~~ *the appropriate capitation premium revenue account*. To identify ~~contractual adjustments~~ *capitation premium revenue* related to specific risk-based capitation plans separately from other capitation premium revenue, use subaccounts within ~~Contractual Adjustments - Other (Account 5850)~~ *the capitation premium revenue accounts*.

ACCOUNTING PRINCIPLES AND CONCEPTS

3. In-house patient care charges for members totaled $178,500, including one in-house patient who had a bill for $38,000. Reinsurance recovery was billed for $3,000 ($38,000 - $35,000).

Dr.	Other Receivables (Account 1069)	$3,000	
Dr.	~~Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025)~~ *Patient Receivables - Other Third Parties - Managed Care (Account 1035)*	$178,500	
Cr.	Reinsurance Recoveries (Account 5781)		$3,000
Cr.	Various Patient Revenue Centers		$178,500

To record in-house inpatient care services rendered to HMO members and the reinsurance recovery of $3,000 claimed for inpatient services.

4. The hospital purchases computed tomography scanner services for $1,200 from another hospital.

Dr.	Computed Tomographic Scanner (Account 7680.61)	$1,200	
Cr.	Accounts Payable (Account 2020)		$1,200

To record CT Scanner services purchased from another hospital for in-house HMO member patients.

5. The hospital records the patient revenue related to the purchased CT scanner services. A 25 percent mark-up on purchased ancillary services is used in this example.

Dr.	Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025.00)	$1,500	
Cr.	Computed Tomographic Scanner (Account 4680)		$1,500

To record Gross Patient Revenue related to CT Scanner services ($1,200 plus 25% mark-up of $300, or $1,500).

NOTE: A mark-up has been added to the cost of the purchased ancillary services prior to recording the gross revenue. This may seem unnecessary for capitated patients since the amount the hospital will collect has already been determined. However, gross revenue related to ancillary services must be recorded consistently for all patients. If the hospital purchases

ancillary services for both capitated and non-capitated patients, the basis for recording gross revenue must be the same. For example, if the hospital purchases CT scanner services for a private pay patient and marks up the cost of the service by "X" percent to determine the charge (gross revenue), then CT scanner services purchased for capitation patients must also be marked-up. Only in this way will gross revenue be comparable among all patients.

6. The hospital does not provide open-heart surgery services. One HMO member was admitted to another hospital for such surgery. The cost was $40,000. [This will result in a $5,000 reinsurance recovery ($40,000 - $35,000).]

Dr.	Purchased Inpatient Services (Account 7900)	$40,000	
Cr.	Accounts Payable (Account 2020)		$40,000

To record inpatient services purchased from another hospital.

~~Dr.~~	~~Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025.00)~~	~~$40,000~~	
~~Cr.~~	~~Purchased Inpatient Services (Account 4900)~~		~~$40,000~~

~~To record revenue for inpatient services purchased from another hospital.~~

Dr.	Other Receivables (Account 1069)	$5,000	
Cr.	Reinsurance Recoveries (Account 5781)		$5,000

To record reinsurance recovery claimed for purchased inpatient services.

7. HMO patients have a copayment requirement of $4 per prescription item. During the month 125 prescription items were issued to inpatients and all were paid. (125 x $4 = $500)

Dr.	General Checking Account (Account 1001)	$500	
Cr.	~~Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025)~~ *Patient Receivables - Other Third Parties - Managed Care (Account 1035.00)*		$500

To record patient copayments collected.

ACCOUNTING PRINCIPLES AND CONCEPTS

8. Reinsurance payments received.

Dr.	General Checking Account (Account 1001)	$8,000	
Cr.	Other Receivables (Account 1069)		$8,000

To record reinsurance recoveries received from the insurance company ($3,000 for hospital patients and $5,000 for purchased inpatient services).

9. Contractual Adjustments were ~~$219,500~~ *$179,500* for hospital inpatient services. [Gross Patient Revenue of $178,500 for inhouse services plus $1,500 for purchased CT scanner services ~~and $40,000 for purchased inpatient services (Entry 6)~~ less copayments of $500 (Entry 7).]

Dr.	Contractual Adjustments ~~- HMO/PPO and Other Contracts (Account 5840)~~ *Other Third Parties - Managed Care (Account 5852)*	~~$219,500~~ *179,500*	
Cr.	~~Inpatient Receivables - HMO/PPO and Other Contracts (Account 1025)~~ *Patient Receivables - Other Third Parties - Managed Care (Account 1035)*		~~$219,500~~ *179,500*

To close in-house capitation patient Accounts Receivable balances to Contractual Adjustments.

10. Capitation fees (when earned) are transferred from the Deferred Income - Capitation Fees account to the Capitation Premium Revenue account.

Dr.	Deferred Income - Capitation Fees (Account 2103.X1)	$150,000	
Cr.	Capitation Premium Revenue - *Other Third Parties* (Account ~~5841~~ *5990)*		$150,000

To transfer capitation fees earned to Capitation Premium Revenue.

ACCOUNTING PRINCIPLES AND CONCEPTS

11. . Risk pool distribution to the hospital was $16,000 and is credited to ~~Contractual Adjustments - Other~~ *Capitation Premium Revenue - Other Third Parties* since it does not relate to specific patients. (Normally the risk pool is distributed at the end of the capitation contract period, however, for illustration purposes it is shown here at the end of the first month.)

Dr.	General Checking Account (Account 1001)	$16,000	
Cr.	~~Contractual Adjustments - HMO/PPO and Other Contracts (Account 5840)~~ *Capitation Premium Revenue - Other Third Parties (Account 5990)*		$16,000

To record risk pool distribution.

The following entries are included only to develop the illustrative income statement shown below.

12. Expenses of the contracting hospital related to patient care and non-revenue producing activities were $100,000 and $40,000, respectively.

Dr.	Various Revenue Producing Cost Centers	$100,000	
Dr.	Various Non-Revenue Producing Cost Centers	$40,000	
Cr.	General Checking Account (Account 1001)		$140,000

To record expenses related to patient care and non-revenue producing activities.

13. Non-operating revenue and expenses were $40,000 and $10,000, respectively.

Dr.	General Checking Account (Account 1001)	$40,000	
Cr.	Other Non-Operating Revenue (Account 9400)		$40,000

To record Non-Operating Revenue.

Dr.	Other Non-Operating Expenses (Account 9800)	$10,000	
Cr.	General Checking Account (Account 1001)		$10,000

To record Non-Operating Expenses.

ACCOUNTING PRINCIPLES AND CONCEPTS

General Checking Account
(1001)

	Dr.		Cr.	
(1)	150,000		16,000	(2)
(7)	500		140,000	(12)
(8)	8,000		10,000	(13b)
(11)	16,000			
(13a)	40,000			
	48,500			

~~Inpatient~~ *Patient* Receivables - ~~HMO/PPO and Other Contracts~~ *Other Third Parties - Managed Care*
(1035)

	Dr.		Cr.	
(3)	178,500		500	(7)
(5)	1,500		~~219,500~~ *179,500*	(9)
~~(6b)~~	~~40,000~~		0	

Other Receivables
(1069)

	Dr.		Cr.	
(3)	3,000			
~~(6c)~~ *(6b)*	5,000		8,000	(8)
	0			

Accounts Payable
(2020)

	Dr.		Cr.	
			1,200	(4)
			40,000	(6a)
			41,200	

Deferred Income - Capitation Fees
(2103.X1)

	Dr.		Cr.	
(10)	150,000		150,000	(1)
			0	

Various Patient Revenue Centers
(XXXX)

	Dr.		Cr.	
			178,500	(3)

Computed Tomographic Scanner Revenue
(4680)

	Dr.		Cr.	
			1,500	(5)

~~Purchased Inpatient Services Revenue~~
~~(4900)~~

	~~Dr.~~		~~Cr.~~	
			~~40,000~~	~~(6b)~~

Reinsurance Recoveries
(5781)

	Dr.		Cr.	
			3,000	(3)
			5,000	~~(6c)~~ *(6b)*
			8,000	

Contractual Adjustments - ~~HMO/PPO And Other Contracts~~ *Other Third Parties- Managed Care*
(~~5840~~ *5852*)

	Dr.		Cr.	
(9)	~~219,500~~ *179,500*		~~16,000~~	~~(11)~~
	~~203,500~~			

ACCOUNTING PRINCIPLES AND CONCEPTS

Capitation Premium Revenue - *Other Third Parties* (~~5841~~ *5990*)

Dr.	Cr.	
	150,000	(10)
	16,000	*(11)*
	166,000	

Computed Tomographic Scanner Purchased Services - Medical (7680.61)

Dr.		Cr.
(4)	1,200	

Purchased Inpatient Services (7900)

Dr.		Cr.
(6a)	40,000	

Various Revenue Producing Cost Centers

Dr.		Cr.
(12)	100,000	

Various Non-Revenue Producing Cost Centers

Dr.		Cr.
(12)	40,000	

Insurance - Other (8840)

Dr.		Cr.
(2)	16,000	

Other Non-Operating Revenue (9400)

Dr.		Cr.	
~~(13a)~~	~~40,000~~	*40,000*	*(13a)*

Other Non-Operating Expense (9800)

Dr.		Cr.
(13b)	10,000	

The following is an illustrative Statement of Income based on the above account balances:

STATEMENT OF INCOME
(ILLUSTRATIVE)

Gross patient revenue	$~~220,000~~ *180,000*
Less deductions from revenue	~~53,500~~ *179,500*
Add capitation premium revenue	*166,000*
Net patient revenue	$166,500
Other operating revenue	8,000
Total operating revenue	$174,500
Operating expenses:	
CT scanner	$ 1,200
Various revenue producing cost centers	100,000
Insurance - other	16,000
Various non-revenue producing centers	40,000
Other patient care services expenses	40,000
Total operating expenses	$197,200
Net from operations	- 22,700
Non-operating revenue	40,000
Non-operating expenses	10,000
Net income	$ 7,300

ACCOUNTING PRINCIPLES AND CONCEPTS

OUTPATIENT SERVICES 1222

~~Under risk-based capitation plans, contracting hospitals usually are not responsible for providing most outpatient services. However, in those cases where the hospital is responsible for outpatient services, the accounting for revenue and expenses for capitation patients is no different from any other hospital outpatient. That is, revenue (recorded at full established rates) and all direct expenses, as defined in this Manual, must be accounted in the functional centers related to the services provided, even if those outpatient services must be purchased from another hospital or organization. For example, if the contracting hospital is responsible for home health care and doesn't have a hospital-based home health agency, the expenses related to purchasing such services must be recorded in the Home Health Care Services cost center (Account 7290) and gross revenue must be recorded in the Home Health Care Services revenue center (Account 4290). Appropriate standard units of service must be maintained along with the number of outpatient visits. Outpatient visits for all contractual purchasers are to be reported on page 3 of the disclosure report and are defined as emergency services visits for all patients not formally admitted as inpatients, hospital-based and satellite clinic visits (count each visit to each separately organized clinic unit), outpatient surgery visits, day and night care medical and psychiatric program visits, observation care visits, renal dialysis visits, home health visits, and referred ancillary services visits by outpatients other than those above (count one visit for an appearance in the hospital, regardless of the number of tests, treatments, and procedures rendered to the patient, or ancillary service centers visited). For complete outpatient visit definitions, see Section 4130.~~

For outpatient services that are provided by a hospital within its own facilities to a registered outpatient, the accounting of the revenue and expenses for capitation patients is no different than that for any other patient. Revenue (recorded at full-established rates) and all direct expenses, as defined in this Manual, must be accounted in the functional centers related to the services provided. However, for outpatient services which must be obtained from another hospital, where the member registers as an outpatient of the other hospital, the accounting for the related revenue and expenses must be accommodated in a different manner.

The following are three situations in which outpatient services are provided to members:

1. *A member is registered as an outpatient in the hospital and all ambulatory and ancillary services are directly provided by that hospital. The gross revenue, expenses, and units of service are recorded in the functional centers related to the services provided.*

2. *A member is registered as an outpatient in the hospital and most, but not all, ancillary services are directly provided by that hospital. For example, the hospital must purchase computed tomographic scanner services from another hospital or organization. Since the patient is a registered outpatient of the purchasing hospital, the gross revenue, expenses, and units of service related to computed tomographic scanner services must be recorded by the purchasing hospital in the computed tomographic scanner services revenue/cost center even though purchased from another hospital.*

ACCOUNTING PRINCIPLES AND CONCEPTS

3. A member does not register as an outpatient of the purchasing hospital but registers as an outpatient at another hospital (or health care facility) with the approval of the purchasing hospital. Since the purchasing hospital is responsible for all of the cost of the services provided by the other hospital, the other hospital will bill the purchasing hospital for the care provided. Because the member was not registered at the purchasing hospital, it is inappropriate to record the expenses and related units of service in the functional cost centers of the purchasing hospital. It is also inappropriate to record any patient revenue by the purchasing hospital related to the services provided by the other hospital. However, since the purchasing hospital is responsible for the cost of the services provided and has received capitation fees to provide all outpatient services, such cost must be recorded as patient service expense in the Purchased Outpatient Services (Account 7950) cost center.

If outpatient services are included in the hospital's agreement with the HMO, the capitation fees would cover both inpatient and outpatient services as specified in the agreement. Such fees would be accounted through ~~contractual adjustments~~ *capitation premium revenue* as indicated in the discussion and example of Inpatient Services above.

OTHER COMMENTS 1223

If the hospital has a need to identify expenses with specific risk-based contracts, the hospital is free to expand upon the required account code structure in this Manual. For example, if *a capitated patient who is formally admitted as an inpatient to the hospital needs* computed tomographic scans ~~are~~ *that must be* purchased from another hospital ~~for capitated patients~~, the required coding would be 7680.61 (7680 for the Computed Tomographic Scan cost center and .61 for Purchased Services - Medical.) To identify the expense with a specific contract - for example, Complete Care Plan - the expanded coding could be 7680.611, or 7680.6101 with the 1 or 01 identifying the Complete Care Plan contract. For purchased inpatient services related to Complete Care Plan *for a patient admitted to another hospital*, the coding would be 7900.611 or 7900.6101. The specific code for the underlined portion of course depends on the expanded coding scheme developed by the hospital.

The hospital which has to purchase inpatient services from another hospital may want to keep track of the cost of those services for each hospital from which they purchased them, or based on the kinds of services purchased. In the first case, the 7900 series could be expanded to indicate that 7901 is Compliance Medical Center, 7902 Pleasantville Convalescent Hospital, etc. Or in the second case, 7901 could mean Medical/Surgical Intensive Care, 7902 - Coronary Care, ~~7951 Computed Tomographic Scan,~~ etc. The numbering scheme within Account 7900 is up to the hospital.

HOSPITAL-SPONSORED HEALTH MAINTENANCE ORGANIZATIONS 1230

If a hospital is sponsoring its own Health Maintenance Organization (HMO) and related Individual Practice Associations (IPA's), it is recommended that the cost of administering the program and the related business transactions be accounted for separately from the hospital's general ledger. The hospital must not report the revenues

and expenses incurred by the HMO (membership premiums, medical expenses, etc.) on the annual disclosure report.

If the hospital cannot maintain two sets of accounting records for the two entities, the HMO operations should be reclassified out of the hospital's general ledger prior to completing the annual disclosure report.

ACCOUNTING FOR ADMINISTRATIVE SERVICES PROVIDED BY OTHER COUNTY AGENCIES 1240

The cost of administrative services provided to the hospital by other county agencies or departments must be recorded and reported by the hospital as a purchased service. The cost of such services must be charged to the appropriate functions. For example, if purchasing and general accounting services are purchased from a county agency or department, the cost of each service must be charged to the appropriate functional cost center.

ACCOUNTING FOR MEDICAL SERVICES PURCHASED FROM ANOTHER FACILITY 1250

The accounting for the purchase of medical services by one hospital from another is the same regardless of financial classification. ~~All revenue~~ *Expenses* for inpatient services purchased from another facility, *where the patient is not admitted to the purchasing hospital*, must be recorded in the Purchased Inpatient Services ~~revenue~~ *cost* center (Account ~~4900~~ *7900*) ~~and the related expenses recorded in Account 7900~~ *by the purchasing hospital. No inpatient revenue is recorded, however, related purchased inpatient days and discharges must be recorded. All expenses for outpatient services purchased from another facility, where the patient is not registered as an outpatient of the purchasing hospital, must be recorded in the Purchased Outpatient Services cost center (Account 7950) by the purchasing hospital. No outpatient revenue or units of service are recorded.* ~~Revenues and expenses for outpatient ancillary and ambulatory services must be recorded in the appropriate revenue/cost center. For example, under the Medi-Cal program, assume Hospital C is a Contracting hospital and Hospital D is a Delegated hospital. Medi-Cal requires the contracting hospital to assume all expenses related to providing patient care to Medi-Cal inpatients, whether provided by the Contracting hospital or a Delegated hospital.~~

When patients are formally admitted as inpatients or registered as outpatients of the hospital, and the hospital must purchase ancillary or ambulatory services from another facility, related revenues and expenses must be recorded in the appropriate revenue/cost center by the purchasing hospital. For example, assume Hospital C must purchase CT Scanner services for a Medi-Cal inpatient from Hospital D. In this case, Hospital D would provide the CT Scanner services on an outpatient basis to the Hospital C patient. Hospital D would record its direct expenses in the CT Scanner cost center and record outpatient revenue at the full established rates using the "~~other third-party payor~~ *Other Third Parties - Traditional*" *payor* category. The difference between full established rates and what Hospital C pays would be recorded ~~as a deduction from revenue~~ *in Contractual Adjustments - Other Third Parties - Traditional (Account 5851).* Hospital D would record the appropriate number of units of service.

Hospital C would pay Hospital D and record the payment in the CT Scanner cost center as medical purchased services. Hospital C would also record CT Scanner

ACCOUNTING PRINCIPLES AND CONCEPTS

inpatient Medi-Cal gross revenue and appropriate Medi-Cal Contractual Adjustments. Hospital C records the same number of units of service counted by Hospital D.

Although this double counts revenues and expenses, only in this way do both hospitals have an accurate accounting of the transactions and comparable revenue and expense per unit figures.

ACCOUNTING FOR COUNTY INDIGENT PROGRAMS AND FUNDS 1260

Effective January 1, 1983, the State transferred responsibility for medically indigent adults to counties and provided a funding mechanism. These persons were, in essence, rolled into the existing county responsibility for indigent health care under Section 17000 of the Welfare and Institutions (W & I) Code.

In September 1989, the California Healthcare for Indigent Program (CHIP) was legislatively created to implement Proposition 99, which imposed a tobacco products tax to provide funding for the health care of the medically indigent and for other purposes. Funding for counties under the Medically Indigent Services Program (MISP) and AB-8 program was eliminated by legislation enacted in 1991. That legislation transferred the responsibility and funding for social services, public health and health from the State to the counties. The program is called "realignment" (See Section 1280 for a discussion on how county hospitals are to account for realignment funds). Under both the CHIP and realignment programs, funding from the State is dependent on each county fulfilling a Maintenance of Effort requirement.

Although the MISP program was eliminated by the "realignment" legislation, the California Medical Services Program (CMSP) still exists. Under CMSP, which was created for counties with a population of less than 3,000,000, the State administers the program for those counties electing to have the State do so. As administrator of the CMSP, the State is responsible for determining patient eligibility and paying hospitals for services provided to patients under this program.

Because of the number of funding sources being used by counties to fund indigent health care, the County Indigent Programs (CIP) payor category, established in this Manual, must be used to consolidate and track the revenue related to all indigent health care for which counties are responsible.

The following applies to all hospitals:

Hospitals providing care to indigent patients for which the county is responsible, whether that is a county hospital or another hospital under arrangements with the county, must account for the CIP patients' charges and related contractual adjustments in the County Indigent Programs payor category. The accounting requirements for CIP patients are the same as for any other sponsored patient. Gross patient revenue based on the hospital's full established rates and the units of service provided are to be recorded for the appropriate revenue centers. A patient receivable account (~~Inpatient~~ *Patient* Receivables - County Indigent Programs - *Traditional,* Account 1024 and ~~Outpatient~~ *Patient* Receivables - County Indigent Programs - *Managed Care,* Account 1034) must be established equal to the gross patient revenue amount. The difference between the amount of the receivable and the amount to be received from the patient (if any) and the responsible county must be charged to the Contractual Adjustments - County Indigent Programs - *Traditional* account (Account ~~5830~~ 5841) *or Contractual Adjustments - County Indigent Programs - Managed Care account (Account 5842)* and credited to the patient's receivable account.

ACCOUNTING PRINCIPLES AND CONCEPTS

(NOTE: The first edition of this Manual required county hospitals to record all unpaid charges to an appropriate charity account. However, this is no longer appropriate since indigent patients must be specifically identified to *either* the County Indigent Programs payor category *or Other Indigent payor category*.)

The following applies to County Hospitals Only:

Under W & I Code Section 17000, counties are required to provide health care to all residents who qualify as indigents under the standards established by each county. In order to distinguish between patients who qualify as indigents and those who don't, all patients must be classified by county hospitals at the time of admission, or as soon as is possible, as being indigent and/or paying patients.

The State distributes CHIP and realignment funds rateably in advance to counties. These funds are either maintained by the County Auditor-Controller or transferred to the county hospital(s). If the funds are transferred to the county hospital's responsibility, they are to be recorded by the hospital as Deferred Income - Other (Account 2093), a sub-account of the Other Liabilities Account. This method of accounting is required since the funds have not yet been earned, but in all probability will be recognized as revenue within 12 months.

If all or part of the patient's account is to be paid from CHIP and/or realignment funds, an amount equal to the payment is then debited to Deferred Income - Other (Account 2093) and credited to the patient's receivable account. If the CHIP and/or realignment funds have been exhausted, no transfer from the Deferred Income - Other account is required. The difference between the patient's gross charges and the amount to be paid by the patient and from CHIP and/or realignment funds must be charged to Contractual Adjustments - County Indigent Programs - *Traditional* (Account ~~5830~~ *5841*).

In some counties, the county hospital(s) does not receive the CHIP and/or realignment funds in advance, but the funds are retained by the County Auditor-Controller, or other county agency. To receive payment, the hospital renders a bill to the Auditor-Controller. This would preclude the use of the Deferred Revenue account in the example above.

There may be times when the county hospital is unable to provide the services required by the indigent patient and another provider must be authorized to render the services. If the county purchases inpatient services from another institutional provider, it is not appropriate for the indigent patient services rendered by an authorized provider to be recorded as a daily hospital service of the county hospital since to do so would distort the revenue and expenses of, and services rendered by, the county hospital. For example, if the patient (census) days of care provided by an authorized hospital were included with the county hospital's statistics, the county hospital's occupancy rate would be distorted. When the authorized hospital's bill is received by the county hospital, the amount must be charged to Purchased Inpatient Services (Account 7900) and an appropriate payable account credited. In addition, a patient receivable account must be established for the amount billed by the authorized hospital with a credit to the Purchased Inpatient Services revenue center (Account 4900). The patient's receivable would be handled in the manner described above.

ACCOUNTING PRINCIPLES AND CONCEPTS

ACCOUNTING FOR MEDI-CAL DISPROPORTIONATE SHARE PAYMENTS 1270

Legislation enacted effective July 30, 1991 (SB 855, Chapter 279) and clarifying legislation enacted effective October 14, 1991 (SB 146, Chapter 1046), provides that additional payments are to be made by the State to disproportionate share hospitals that provide acute care inpatient services to Medi-Cal beneficiaries. Funding for the additional payments is provided by intergovernmental transfers from public entities (counties, hospital districts, and the University of California) to the State. Amounts transferred are matched with Federal Medicaid funds. The disproportionate share funds are paid to disproportionate share hospitals as a supplemental amount for each Medi-Cal day of care paid for by the Medi-Cal Fiscal Intermediary.

Approval of the disproportionate share payment program by the Health Care Financing Administration was effective retroactive to August 17, 1991.

The intergovernmental transfer payments are to be made to the State Controller's Office (SCO) by public entities (counties, hospital districts, and the University of California system) and may not be made directly by the hospital, and therefore are not recorded in its books and records. This is consistent with Section 14163 (e) of the Welfare and Institutions Code which provides that the intergovernmental transfers to fund the disproportionate share program are to be made to the SCO by the public entity that is the licensee of each identified eligible hospital.

After July 1st of each year, the Department of Health Services notifies eligible hospitals of the estimated disproportionate share amounts to be disbursed, and the rate associated with each Medi-Cal paid claim day. Normally, disproportionate share payment amounts related to the SB 855 program will be received concurrently with the hospital's regular Medi-Cal payments, and therefore, recorded when such payments are received from the Medi-Cal intermediary. However, due to delays in the availability of the disproportionate share funds, disproportionate share payments may be delayed. When such delays occur, it is appropriate to accrue the delayed payments. Such accruals are to be based on the disproportionate share daily rate and the number of Medi-Cal paid claim days for the applicable hospital fiscal year. Disproportionate share payments must not be based on when services are rendered to Medi-Cal inpatients. To avoid over accruals of disproportionate share funds, hospitals should be aware that disproportionate share payments may not exceed 80 percent of its prior calendar year Medi-Cal paid days.

Supplemental disproportionate share payment amounts are to be recorded and reported in full as a credit to Disproportionate Share Payments for Medi-Cal Patient Days (Account ~~5821~~ *5830*~~), a sub-account of Contractual Adjustments - Medi-Cal (Account 5820)~~. This is consistent with Section 14105.98 (d) (1) of the Welfare and Institutions Code which specifies that the disproportionate share payment amounts "shall be distributed as a supplement to . . . payments on all billings for Medi-Cal acute inpatient hospital services that are paid through the Medi-Cal claims payment systems .

Although inconsistent with the funding provisions of the law, the public entity may require the hospital to remit certain portions of the disproportionate share payments to the public entity. In this instance, these amounts are to be recorded on the

ACCOUNTING PRINCIPLES AND CONCEPTS

hospital's books as a reduction to the Unrestricted Fund Balance. This transfer must not be recorded as a debit to Disproportionate Share Payments for Medi-Cal Patient Days (Account ~~5821~~ *5830*) or Contractual Adjustments - Medi-Cal (Account 5820), or recorded as an operating or non-operating expense. This is consistent with the requirements of the State Controller's Office and reflects the fact that SB-855 does not require the remittance of received payments to the public entities.

The following entries indicate how the supplemental amounts are to be recorded by eligible hospitals.

Assumptions: The hospital's Medi-Cal contract rate is $1,500 per patient day and the additional disproportionate share payment rate is $300 per paid Medi-Cal patient day.

1. To record patient care services rendered to Medi-Cal inpatients:

Dr. ~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional* (Account 1023)	$60,000	
Cr. Revenue (Various Accounts)		$60,000

2. To record contractual adjustments related to the 30 patient days of services recorded in 1. above, based on contract rate [$60,000 - $45,000 ($1,500 x 30 days)]:

Dr. Contractual Adjustments - Medi-Cal (Account 5820)	$15,000	
Cr. ~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional* (Account 1023)		$15,000

3. To record receipt of $22,500 for 15 days of Medi-Cal inpatient services ($1,500 x 15 days) and $4,500 in additional disproportionate share payments ($300 x 15 days):

Dr. Cash (Account 1000)	$27,000	
Cr. ~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional* (Account 1023)		$22,500
Cr. Disproportionate Share Payments for Medi-Cal Patient Days (Account ~~5821~~ *5830*)		$ 4,500

4. (Same as entry no.3, except disproportionate share payments to the hospitals have been delayed.) To record receipt of $22,500 for 15 days of Medi-Cal inpatient services ($1,500 x 15 days) and to recognize of $4,500 in additional disproportionate share payments ($300 x 15 days):

Dr. Cash (Account 1000)	$22,500	

ACCOUNTING PRINCIPLES AND CONCEPTS

Dr. Other Receivables (Account 1060)	$4,500	
Cr. ~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional* (Account 1023)		$22,500
Cr. Disproportionate Share Payments for Medi-Cal Patient Days (Account ~~5821~~ *5830*)		$4,500

5. To record receipt of disproportionate share payments:

Dr. Cash (Account 1000)	$4,500	
Cr. Other Receivables (Account 1060)		$4,500

~~Even though the disproportionate share payment amounts are recorded in a sub-account of Contractual Adjustments - Medi-Cal (Account 5820), the separate reporting of this sub-account is required. On the 1992 quarterly reporting form, line 143 (Disproportionate Share Payments for Medi-Cal Patient Days) was added; and on Report Pages 8 and 12 of the revised annual disclosure report, lines 46 and 426 (Disproportionate Share Payments for Medi-Cal Patient Days), respectively, were added. The revised annual reporting requirements become effective with report periods ending on and after December 31, 1992. For annual reporting periods ending before December 31, 1992, which are covered by the reporting requirements of the First Edition Manual, disproportionate share payments are to be included on line 45 (Medi-Cal Contractual Adjustments) of Report Page 8.~~

If the public entity requires the hospital to transfer portions of the disproportionate share payments to the public entity, the following entry would be made:

Dr. Unrestricted Fund Balance (Account 2310)	$10,000	
Cr. Cash (Account 1000)		$10,000

If the public entity receives lump-sum retroactive disproportionate share payments for services rendered in previous payment years, the following entry would be made:

Dr. Cash (Account 1000)	$100,000	
Cr. Other Non-Operating Revenue (Account 9400)		$100,000

ACCOUNTING PRINCIPLES AND CONCEPTS

ACCOUNTING FOR REALIGNMENT FUNDS (County Hospitals Only) 1280

Three bills, AB-1288 (Chapter 89), AB-948 (Chapter 91), and AB-1491 (Chapter 611), were enacted in 1991 to transfer the responsibility and funding for social, health, and mental health services from the State to the counties. The transfer was called "realignment." In addition, the above legislation eliminated State funding for the Medically Indigent Services Program (MISP) and the AB-8 Program.

Funding for the realignment program comes from an increase in sales tax and in vehicle license fees. The increase in sales tax is split by the State Controller, as specified in the legislation, among Social, Mental Health, and Health services. The funds in the three accounts are transferred by the State Controller to the counties. The funds transferred must retain their program designation and be deposited by the County Auditor-Controller in separate accounts within the Local Health and Welfare Trust Fund. The increase in the vehicle license fees is transferred by the State Controller to the County General Fund. An amount equal to twice the amount of the increased vehicle license fees must be transferred by the county to the Health Account in the Local Health and Welfare Trust Fund.

The funds in the Health Account of the Local Health and Welfare Trust Fund can be used for both Health and public health programs. In most cases, the funds designated by the county for the county hospital programs will be used (1) to provide indigent health care services, (2) to cover the shortage between patient and other operating revenue and operating expenses, and (3) to cover other expenses. Funds in the Mental Health Account of the Local Health and Welfare Trust Fund may also be designated by the county to the county hospital.

The following describes the typical accounting treatment for health care services rendered to an indigent patient by a county hospital using realignment funds. For services rendered to indigent patients, gross patient revenue, based on the full established rates, is recorded in the County Indigent Programs payor category for various revenue centers. A patient receivable account is established equal to the gross revenue amount. The county hospital renders a bill to the County Auditor-Controller for the services provided by the hospital for specific patients. The Auditor-Controller pays all or part of the bill from the Local Health and Welfare Trust Fund and transfers the payment amount to the hospital. The amount of the payment is credited to the patient's accounts receivable balance and debited to the cash account by the hospital. The difference between the amount of the patient receivable and the amount paid, i.e., the unpaid amount of the receivable, is recorded as Contractual Adjustments - County Indigent Programs - *Traditional* (Account ~~5830~~ *5841*), and credited to the patient's receivable account.

In some counties, the county allocates a certain amount of the realignment funds to the county hospital for indigent patient care but the funds are not identified for the care of specific patients. Since the funds are not identified with specific patients, the realignment funds received by the county hospital are to be recorded as a credit to Contractual Adjustment - County Indigent Programs - *Traditional* (Account ~~5830~~ *5841*). In order to account for the realignment funds received within the period in which the funds are used, a deferred income account may need to be established within the balance sheet liability accounts.

SYSTEM OF ACCOUNTS

SYSTEM OF ACCOUNTS

SYSTEM OF ACCOUNTS

CHART OF ACCOUNTS - BALANCE SHEET **2100**

UNRESTRICTED FUND ASSETS **2110**

Current Assets **2110.1**

1000 - 1009	CASH	
1001.00	General Checking Accounts	
1002.00	Payroll Checking Accounts	
1003.00	Other Checking Accounts	
1004.00	Imprest Cash Funds	
1005.00	Savings Accounts	
1006.00	Certificates of Deposit	
1007.00	Treasury Bills and Treasury Notes	
1009.00	Other Cash Accounts	
1010 - 1019	MARKETABLE SECURITIES	
1011.00	Unrestricted Marketable Securities	
1019.00	Other Current Investments	
1020 - 1039	ACCOUNTS AND NOTES RECEIVABLE	
1021.00	~~Inpatient~~ *Patient* Receivables - Unbilled	
1022.00	~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional*	
1023.00	~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional*	
1024.00	~~Inpatient~~ *Patient* Receivables - County Indigent Programs - *Traditional*	
1025.00	~~Inpatient~~ *Patient* Receivables - ~~HMO/PPO and Other Contracts~~ *Other Third Parties - Traditional*	
1026.00	~~Inpatient~~ *Patient* Receivables - Other	
1027.00	Medicare PIP Clearing	

SYSTEM OF ACCOUNTS

1028.00	Clearing - Other
~~1031.00~~	~~Outpatient Receivables - Unbilled~~
1032.00	~~Outpatient~~ *Patient* Receivables - Medicare - *Managed Care*
1033.00	~~Outpatient~~ *Patient* Receivables - Medi-Cal - *Managed Care*
1034.00	~~Outpatient~~ *Patient* Receivables - County Indigent Programs - *Managed Care*
1035.00	~~Outpatient~~ *Patient* Receivables - ~~HMO/PPO and Other Contracts~~ *Other Third Parties - Managed Care*
1036.00	~~Outpatient~~ *Patient* Receivables - Other *Indigent*
1040 - 1049	ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES AND THIRD- PARTY CONTRACTUAL WITHHOLDS
1041.00	Allowance for Bad Debts
1042.00	Allowance for Contractual Adjustments - Medicare ~~Inpatient~~ *Traditional*
1043.00	Allowance for Contractual Adjustments - Medicare ~~Outpatient~~ *Managed Care*
1044.00	Allowance for Contractual Adjustments - Medi-Cal ~~Inpatient~~ *Traditional*
1045.00	Allowance for Contractual Adjustments - Medi-Cal ~~Outpatient~~ *Managed Care*
1046.00	Allowance for Contractual Adjustments - County Indigent Programs
1047.00	Allowance for Contractual Adjustments - ~~HMO/PPO Inpatient~~ *Other Third Parties - Traditional*
1048.00	Allowance for Contractual Adjustments - ~~HMO/PPO Outpatient~~ *Other Third Parties - Managed Care*
1049.00	Allowance for Contractual Adjustments - Other

SYSTEM OF ACCOUNTS

1535.00	Accrued Interest Receivable
1537.00	Notes Receivable
1539.00	Other Receivables
1540 - 1549	DUE FROM OTHER FUNDS
1541.00	Due from Unrestricted Fund
1542.00	Due from Plant Replacements and Expansion Fund
1543.00	Due from Endowment Fund
1550 - 1599	OTHER ASSETS

ENDOWMENT FUND ASSETS **2140**

1610 - 1619	CASH
1611.00	Checking Accounts
1612.00	Savings Accounts
1613.00	Certificates of Deposit
1619.00	Other Cash Accounts
1620 - 1629	INVESTMENTS
1621.00*	Marketable Securities
1622.00*	Mortgages
1623.00*	Real Property
1624.00*	Accumulated Depreciation on Real Property
1629.00*	Other Investments
	*Reportable even though not zero-level accounts.
1630 - 1639	RECEIVABLES
1631.00	Legacies and Bequests *Receivable*
1632.00	Pledges *Receivable*

SYSTEM OF ACCOUNTS

4610	ELECTROMYOGRAPHY
4620	ELECTROENCEPHALOGRAPHY
4630	RADIOLOGY - DIAGNOSTIC
4631	Angiocardiography
4639	Other Radiology - Diagnostic
4640	RADIOLOGY - THERAPEUTIC
4641	Chemotherapy
4642	Radiation Therapy
~~4643~~	~~Therapeutic Radioisotope~~
~~4644~~	~~Radioactive Implants~~
4649	Other Radiology - Therapeutic
4650	NUCLEAR MEDICINE
4651	Diagnostic
4652	Therapeutic
4653	Therapeutic Radioisotope
4654	Radioactive Implants
4660	MAGNETIC RESONANCE IMAGING
4670	ULTRASONOGRAPHY
4680	COMPUTED TOMOGRAPHIC SCANNER
4710	DRUGS SOLD TO PATIENTS
4720	RESPIRATORY THERAPY
4730	PULMONARY FUNCTION SERVICES
4740	RENAL DIALYSIS
4750	LITHOTRIPSY
4760	GASTRO-INTESTINAL SERVICES
4761	Endoscopy
4769	Other Gastro-Intestinal Services

SYSTEM OF ACCOUNTS

4770	PHYSICAL THERAPY
4771	Sportscare Medicine
4779	Other Physical Therapy
4780	SPEECH-LANGUAGE PATHOLOGY
4790	OCCUPATIONAL THERAPY
4800	OTHER PHYSICAL MEDICINE
4801	Audiology Services
4802	Recreational Therapy
4809	Other Physical Medicine
4820	ELECTROCONVULSIVE THERAPY
4830	PSYCHIATRIC/PSYCHOLOGICAL TESTING
4840	PSYCHIATRIC INDIVIDUAL/GROUP THERAPY
4860	ORGAN ACQUISITION
4861	Heart Acquisition
4862	Kidney Acquisition
4863	Bone Marrow Acquisition
4869	Other Organ Acquisition
4870	OTHER ANCILLARY SERVICES
4871	Peripheral Vascular Laboratory
4872	Positron Emission Tomography
4873	Treatment Room Services
4874	Sleep Laboratory
4875	Biofeedback Therapy
4876	Industrial Medicine
4877	Infertility Services
~~4900~~	~~PURCHASED INPATIENT SERVICES~~

Other Operating Revenue **2210.4**

5010	TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES
5220	SCHOOL OF NURSING TUITION

SYSTEM OF ACCOUNTS

5680	REBATES AND REFUNDS
5690	VENDING MACHINE COMMISSIONS
5700	MEDICAL RECORDS ABSTRACT SALES
5710	OTHER COMMISSIONS
5720	TELEVISION/RADIO RENTALS
5730	NON-PATIENT ROOM RENTALS
5740	MANAGEMENT SERVICES REVENUE
5750	DONATED BLOOD
5760	CHILD CARE SERVICES REVENUE - EMPLOYEES
5770	COMMUNITY HEALTH EDUCATION REVENUE
5780	OTHER OPERATING REVENUE
5781	* REINSURANCE RECOVERIES
5782	* WORKERS' COMPENSATION REFUNDS
5783	Malpractice Insurance Refunds
5790	TRANSFERS FROM RESTRICTED FUNDS FOR OTHER OPERATING EXPENSES

Deductions From Revenue **2210.5**

5800	PROVISION FOR BAD DEBTS
5810	CONTRACTUAL ADJUSTMENTS - MEDICARE
5811	**CONTRACTUAL ADJUSTMENTS - MEDICARE - TRADITIONAL*
5812	**CONTRACTUAL ADJUSTMENTS - MEDICARE - MANAGED CARE*
5820	CONTRACTUAL ADJUSTMENTS - MEDI-CAL
5821	~~* DISPROPORTIONATE SHARE PAYMENTS FOR MEDI-CAL PATIENT DAYS (CREDIT BALANCE)~~ **CONTRACTUAL ADJUSTMENTS - MEDI-CAL - TRADITIONAL*
5822	**CONTRACTUAL ADJUSTMENTS - MEDI-CAL - MANAGED CARE*
5830	~~CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS~~ *DISPROPORTIONATE SHARE PAYMENTS FOR MEDI-CAL PATIENT DAYS (CREDIT BALANCE)*

** Reportable even though not a zero-level account.*

SYSTEM OF ACCOUNTS

5840	CONTRACTUAL ADJUSTMENTS - ~~HMO/PPO AND OTHER CONTRACTS~~ *COUNTY INDIGENT PROGRAMS*
5841	~~* CAPITATION PREMIUM REVENUE~~ **CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS - TRADITIONAL*
5842	**CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS - MANAGED CARE*
5850	CONTRACTUAL ADJUSTMENTS - OTHER *THIRD PARTIES*
5851	~~Contractual Adjustments - Short-Doyle~~ ** CONTRACTUAL ADJUSTMENTS - OTHER THIRD PARTIES - TRADITIONAL*
5852	~~Contractual Adjustments - Tricare (CHAMPUS)~~ **CONTRACTUAL ADJUSTMENTS - OTHER THIRD PARTIES - MANAGED CARE*
5860	CHARITY DISCOUNTS - HILL-BURTON
5870	CHARITY DISCOUNTS - OTHER
5880	RESTRICTED DONATIONS AND SUBSIDIES FOR INDIGENT CARE (CREDIT BALANCE)
5890	TEACHING ALLOWANCES
5910	SUPPORT FOR CLINICAL TEACHING (CREDIT BALANCE)
~~5970~~ *5920*	POLICY DISCOUNTS
~~5980~~ *5930*	ADMINISTRATIVE ADJUSTMENTS
~~5990~~ *5940*	OTHER DEDUCTIONS FROM REVENUE

**Reportable even though not a zero-level account.*

Capitation Premium Revenue **2210.6**

5960	*CAPITATION PREMIUM REVENUE - MEDICARE*
5970	*CAPITATION PREMIUM REVENUE - MEDI-CAL*
5980	*CAPITATION PREMIUM REVENUE - COUNTY INDIGENT PROGRAMS*
5990	*CAPITATION PREMIUM REVENUE - OTHER THIRD PARTIES*

SYSTEM OF ACCOUNTS

7320	ADULT DAY HEALTH CARE
7390	OTHER AMBULATORY SERVICES

Ancillary Service Expense **2220.3**

7400	LABOR AND DELIVERY SERVICES
7401	Birthing Room
7402	Satellite Birthing Center
7420	SURGERY AND RECOVERY SERVICES
7421	Surgery - General (Major)
7422	Surgery - Organ Transplants
7423	Surgery - Open Heart
7424	Surgery - Neurology
7425	Surgery - Orthopedic
7426	Surgery - Minor
7427	Recovery Room Services
7429	Other Surgery Services
7430	AMBULATORY SURGERY SERVICES
7450	ANESTHESIOLOGY
7470	MEDICAL SUPPLIES SOLD TO PATIENTS
7480	DURABLE MEDICAL EQUIPMENT
7481	Durable Medical ~~Supplies~~ *Equipment* - Rented
7482	Durable Medical ~~Supplies~~ *Equipment* - Sold
7500	CLINICAL LABORATORY SERVICES
7501	Hematology
7502	Microbiology
7503	Chemistry
7504	Immunology (Serology)
7509	Other Clinical Laboratory Services
7520	PATHOLOGICAL LABORATORY SERVICES
7521	Autopsy
7522	Surgical
7523	Cytology
7529	Other Pathological Laboratory Services

SYSTEM OF ACCOUNTS

7740	RENAL DIALYSIS
7750	LITHOTRIPSY
7760	GASTRO-INTESTINAL SERVICES
7761	Endoscopy
7769	Other Gastro-Intestinal Services
7770	PHYSICAL THERAPY
7771	Sportscare Medicine
7779	Other Physical Therapy
7780	SPEECH-LANGUAGE PATHOLOGY
7790	OCCUPATIONAL THERAPY
7800	OTHER PHYSICAL MEDICINE
7801	Audiology Services
7802	Recreational Therapy
7809	Other Physical Medicine
7820	ELECTROCONVULSIVE THERAPY
7830	PSYCHIATRIC/PSYCHOLOGICAL TESTING
7840	PSYCHIATRIC INDIVIDUAL/GROUP THERAPY
7860	ORGAN ACQUISITION
7861	Heart Acquisition
7862	Kidney Acquisition
7863	Bone Marrow Acquisition
7869	Other Organ Acquisition
7870	OTHER ANCILLARY SERVICES
7871	Peripheral Vascular Laboratory
7872	Positron Emission Tomography
7873	Treatment Room Services
7874	Sleep Laboratory
7875	Biofeedback Therapy
7876	Industrial Medicine
7877	Infertility Services
7900	PURCHASED INPATIENT SERVICES
7950	*PURCHASED OUTPATIENT SERVICES*

SYSTEM OF ACCOUNTS

8670	AUXILIARY GROUPS
8680	CHAPLAINCY SERVICES
8690	MEDICAL LIBRARY
8700	MEDICAL RECORDS
8710	MEDICAL STAFF ADMINISTRATION
8720	NURSING ADMINISTRATION
8730	NURSING FLOAT PERSONNEL
8740	INSERVICE EDUCATION - NURSING
8750	UTILIZATION MANAGEMENT
8751	Utilization Review
8752	Quality Assurance
8753	Infection Control
8754	Risk Management
8770	COMMUNITY HEALTH EDUCATION
8790	OTHER ADMINISTRATIVE SERVICES
8791	Health Information Services
8792	Family Support Services
8793	Employee Housing

Unassigned Costs **2220.9**

8810	DEPRECIATION AND AMORTIZATION
8811	Depreciation and Amortization - Buildings and Improvements
8812	Depreciation and Amortization - Leasehold Improvements
8813	Depreciation and Amortization - Fixed Equipment
8820	LEASES AND RENTALS
8821	Leases and Rentals - Building
8822	Leases and Rentals - *Fixed* Equipment
8830	INSURANCE - HOSPITAL AND PROFESSIONAL MALPRACTICE
8840	INSURANCE - OTHER

SYSTEM OF ACCOUNTS

SUBCLASSIFICATIONS OF PATIENT SERVICE REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE 2230

DECIMAL POINT	Digit	Patient Classification (1) Description	Digit	Financial Status Classification (1) Description
.	0	Inpatient - *Traditional (2)*	0	Self-Pay
.	1	~~Optional~~ *Inpatient - Managed Care (3)*	1	~~HMO/PPO Contracts (2)~~ *Not Assigned*
.	2	~~Optional~~ *Not Assigned*	2	~~Commercial Insurance~~ *Private Coverage*
.	3	~~Optional~~ *Not Assigned*	3	Workers' Compensation
.	4	Outpatient - *Traditional (2)*	4	Medicare
.	5	~~Optional~~ *Outpatient - Managed Care (3)*	5	Medi-Cal
.	6	~~Optional~~ *Not Assigned*	6	~~Short-Doyle~~ *Other Government*
.	7	~~Optional~~ *Not Assigned*	7	County Indigent Programs
.	8	~~Optional~~ *Not Assigned*	8	~~Charity~~ *Other Indigent*
.	9	Non-Patient	9	Other

(1) All classifications are required unless logs are maintained.

(2) ~~Includes managed care contracts funded by Medicare and Medi-Cal.~~ *Traditional patients are patients covered by the Medicare prospective payment system, indemnity plans, and fee-for-service plans.*

(3) Managed care patients are patients enrolled in a managed care plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations, Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations, Exclusive Provider Organizations, Exclusive Provider Organizations with Point-of-Service option, etc.).

Note: Subclassification of Other Operating and Non-Operating Revenue not required, but if subclassification is used for other operating and non-operating revenue, then use .99.

SYSTEM OF ACCOUNTS

NATURAL CLASSIFICATION OF EXPENSE **2240**

Salaries and Wages **2240.1**

.00 MANAGEMENT AND SUPERVISION

.01 TECHNICIANS AND SPECIALISTS

.02 REGISTERED NURSES

.03 LICENSED VOCATIONAL NURSES

.04 AIDES AND ORDERLIES

.05 CLERICAL AND OTHER ADMINISTRATIVE

.06 ENVIRONMENTAL AND FOOD SERVICE

.07 PHYSICIANS

.08 NON-PHYSICIAN MEDICAL PRACTITIONERS

.09 OTHER SALARIES AND WAGES

Employee Benefits **2240.2**

.10 FICA

.11 SUI AND FUI

.12 VACATION, HOLIDAY, AND SICK LEAVE

.13 GROUP HEALTH INSURANCE

.14 GROUP LIFE INSURANCE

.15 PENSION AND RETIREMENT

.16 WORKERS' COMPENSATION INSURANCE

.18 OTHER PAYROLL RELATED EMPLOYEE BENEFITS

.19 OTHER *EMPLOYEE BENEFITS* (NON-PAYROLL RELATED)

Professional Fees **2240.3**

.20 MEDICAL - PHYSICIANS

SYSTEM OF ACCOUNTS

Notes receivable and accounts receivable may also be segregated, but there is usually little to be gained from this practice, as the amount of notes receivable will usually be nominal. Such segregation, therefore, is not required.

1021.00 ~~Inpatient~~ *Patient* Receivables - Unbilled

This account shall reflect all unbilled charges and credits (at the hospital's full established rates) for medical services rendered to patients ~~admitted to the hospital~~.

1022.00 ~~Inpatient~~ *Patient* Receivables - Medicare - *Traditional*

The balance in this account reflects all unpaid ~~inpatient~~ *patient* charges billed to the Medicare intermediary. Direct billings to the Medicare ~~inpatient~~ *patient* (or to the Medi-Cal intermediary) for deductibles, co-insurance, and other patient-chargeable items would also be included in this account if such billings were not included in ~~Inpatient Receivables - Other (or Inpatient Receivables - Medi-Cal)~~ *another patient receivable account*.

1023.00 ~~Inpatient~~ *Patient* Receivables - Medi-Cal - *Traditional*

The balance in this account reflects all unpaid ~~inpatient~~ *patient* charges billed to the Medi-Cal intermediary. Direct billings to the Medi-Cal ~~inpatient~~ *patient* (or to the Medicare intermediary) for deductibles, co-insurance, other patient-chargeable items, and "Part B" coverage, would also be included in this account if such billings are not included in ~~Outpatient Receivables - Other (or Outpatient Receivables - Medicare)~~ *another patient receivable account*.

1024.00 ~~Inpatient~~ *Patient* Receivables - County Indigent Programs - *Traditional*

The balance in this account reflects all unpaid charges for medical services and supplies provided to ~~inpatients~~ *patients* for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), Medically Indigent Services Program (MISP) California Health Care for Indigents Program (CHIP) or State and County AB-8 (or future State subsidy programs) for which the hospital renders to the County a bill or other claim for payment.

1025.00 ~~Inpatient~~ *Patient* Receivables - ~~HMO/PPO and Other Contracts~~ *Other Third Parties - Traditional*

The balance in this account reflects all unpaid ~~inpatient~~ *patient* charges billed to third party payors that have contracted with the hospital. Examples of these third party payors may include ~~HMO's, PPO's, Employers, and Unions~~ *indemnity plans or fee-for-service plans*. It may also include deductibles and co-insurance billed to secondary payors or the patient if those receivables were not included in another ~~inpatient~~ *patient* receivable account.

SYSTEM OF ACCOUNTS

1026.00 ~~Inpatient~~ *Patient* Receivables - Other

Include in this account all unpaid ~~inpatient~~ *patient* billings for medical services and supplies provided to all non-Medicare, non-Medi-Cal, ~~non-County Indigent Programs, and non-HMO/PPO~~ *non-Indigent, and non-Other Third Parties*. Direct billings to Medicare and Medi-Cal ~~outpatients~~ *patients* for deductibles, co-insurance, and other patient-chargeable items, may also be included if they are not included elsewhere.

1027.00 Medicare PIP Clearing

The purpose of a clearing account is to reflect the balance of cash received that has not yet been applied to specific accounts receivable. For Medicare purposes this account will reflect the difference between amounts billed to the intermediary for services rendered and periodic interim payments (PIP) received from the intermediary. The hospital should reconcile this account on a periodic basis. Variances that cannot be reconciled at year-end should be written off to the contractual adjustment account (~~5810~~ *5811*). For further discussion on the accounting for PIP see section 1200.

1028.00 Clearing - Other

This account functions in the same manner as the Medicare PIP Clearing. This account is for other payors such as capitated HMO contracts.

~~1031.00~~ ~~Outpatient Receivables - Unbilled~~

~~This account reflects all unbilled charges and credits (at the hospitals full established rates) for medical services rendered to outpatients.~~

1032.00 ~~Outpatient~~ *Patient* Receivables - Medicare - *Managed Care*

The balance in this account reflects all unpaid ~~outpatient~~ *patient* charges ~~billed to~~ *and patient charges that have not been written off to the Contractual Adjustments - Medicare - Manage Care account for medical services and supplies provided to patients covered by managed care plans funded by* ~~the~~ Medicare ~~intermediary~~. Direct billings to the Medicare *managed care* ~~outpatient~~ *patient* ~~(or to the Medi-Cal intermediary)~~ for deductibles, co-insurance, and other patient-chargeable items would also be included in this account ~~if such billings were not included in Outpatient Receivables - Other (or Outpatient Receivables - Medi-Cal)~~.

1033.00 ~~Outpatient~~ *Patient* Receivables - Medi-Cal - *Managed Care*

The balance in this account reflects all unpaid ~~outpatient~~ *patient* charges ~~billed to~~ *and patient charges that have not been written off to the Contractual Adjustments - Medi-Cal - Managed Care account for medical services and supplies provided to patients covered by managed care plans funded by* ~~the~~

SYSTEM OF ACCOUNTS

Medi-Cal ~~intermediary~~. Direct billings to the Medi-Cal *managed care* ~~outpatient~~ *patient* ~~(or to the Medicare intermediary)~~ for deductibles, co-insurance, *and* other patient-chargeable items ~~and items under "Part B" Medicare coverage~~ would also be included in this account. ~~if such billings were not included in Outpatient Receivables - Other (or Outpatient Receivables -Medicare)~~.

1034.00 ~~Outpatient~~ *Patient* Receivables - County Indigent Programs - *Managed Care*

The balance in this account reflects all unpaid charges *and patient charges that have not been written off to the Contractual Adjustments - County Indigent Programs - Managed Care account* for medical services and supplies provided to ~~outpatients~~ *patients* for whom counties are responsible under Welfare and Institutions (W&I) Code Section 17000, ~~including those programs funded in whole or part by County Medical Services Program (CMSP), Medically Indigent Services Program (MISP) California Health Care for Indigents Program (CHIP) or State and County AB-8 (or future State subsidy programs) for which the hospital renders to the County a bill or other claim for payment~~ *and are covered by a managed care plan funded by a county*.

1035.00 ~~Outpatient~~ *Patient* Receivables - ~~HMO/PPO and Other Contracts~~ *Other Third Parties -Managed Care*

The balance in this account reflects all unpaid ~~outpatient~~ *patient* charges billed to ~~third party payors~~ *managed care plans other than those funded by Medicare, Medi-Cal, or a county* that have contracted with the hospital, *and Other Third Parties - Managed Care patient charges that have not been written off to the Contractual Adjustments - Other Third Parties - Managed Care account*. Examples of ~~these third party payors may~~ *managed care plans* include HMO's, PPO's, *and EPO's* ~~Employers, and Unions~~. It may also include deductibles and co-insurance billed to secondary payors or the patient if those receivables were not included in another ~~outpatient~~ *patient* receivable account.

1036.00 Patient Receivables - Other Indigent

The balance in this account reflects all unpaid charges for medical services and supplies provided to indigent patients, excluding those recorded in the County Indigent Programs category and including those who are being provided charity care by the hospital.

1040 - 1049 ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES AND THIRD-PARTY CONTRACTUAL WITHHOLDS

1041.00 Allowance for Bad Debts

1042.00 Allowance for Contractual Adjustments - Medicare ~~Inpatient~~ - *Traditional*

1043.00 Allowance for Contractual Adjustments - Medicare ~~Outpatient~~ - *Managed Care*

SYSTEM OF ACCOUNTS

1044.00	Allowance for Contractual Adjustments - Medi-Cal ~~Inpatient~~ - *Traditional*
1045.00	Allowance for Contractual Adjustments - Medi-Cal ~~Outpatient~~ - *Managed Care*
1046.00	Allowance for Contractual Adjustments - County Indigent Programs
1047.00	Allowance for Contractual Adjustments - ~~HMO/PPO Inpatient~~ *Other Third Parties - Traditional*
1048.00	Allowance for Contractual Adjustments - ~~HMO/PPO Outpatient~~ *Other Third Parties - Managed Care*
1049.00	Allowance for Contractual Adjustments - Other

These are valuation (or contra-asset) accounts whose credit balances represent the estimated amount of uncollectible receivables from patients and third-party payors. For details on the computation of the related deductions from revenue, see the account descriptions of the Deductions from Revenue accounts included in Section 2410.5.

1050 - 1059 RECEIVABLES FROM THIRD-PARTY PAYORS

1051.00	Other Receivables - Third-Party Cost Report Settlement - Medicare
1052.00	Other Receivables - Third-Party Cost Report Settlement - Medi-Cal
1053.00	Other Receivables - Third-Party Cost Report Settlement - Other
1054.00	Outlier Payments due from Medicare

The balances of these accounts reflect the amount due from third-party programs based upon cost reports submitted and/or audited. Sub-accounts should be maintained for each year's settlement if more than one year's settlement is included in an account.

1060 - 1069 PLEDGES AND OTHER RECEIVABLES

1061.00	Pledges Receivable
1062.00	Allowance for Uncollectible Pledges
1063.00	Grants and Legacies Receivable

SYSTEM OF ACCOUNTS

4840 PSYCHIATRIC INDIVIDUAL/GROUP THERAPY

4860 ORGAN ACQUISITION

4870 OTHER ANCILLARY SERVICES

~~4900 PURCHASED INPATIENT SERVICES~~

Other Operating Revenue **2410.4**

5010 TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES

This account reflects the amount of transfers from restricted funds to the Unrestricted Fund to match expenses incurred in the current period by the Unrestricted Fund for restricted fund research activities. Separate accounts must be maintained for each specific restricted fund activity or group of activities for which separate accounting is required by law, grant, or donation agreement.

5220 SCHOOL OF NURSING TUITION

5230 LICENSED VOCATIONAL NURSE PROGRAM TUITION

5240 MEDICAL POSTGRADUATE EDUCATION TUITION

5250 PARAMEDICAL EDUCATION TUITION

5260 STUDENT HOUSING REVENUE

5270 OTHER HEALTH PROFESSION EDUCATION REVENUE

These accounts are used to record the revenue from the School of Nursing, Licensed Vocational Nurse Program, medical post-graduate, paramedical education, student housing, and other educational activities.

5280 TRANSFERS FROM RESTRICTED FUNDS FOR EDUCATION EXPENSES

These accounts reflect the amounts of transfers from restricted funds to the Unrestricted Fund to match expenses incurred in the current period by the Unrestricted Fund for restricted fund activities. Separate accounts must be maintained for each specific restricted fund activity or group of activities for which separate accounting is required by law or grant or donation agreement.

SYSTEM OF ACCOUNTS

5700 MEDICAL RECORDS ABSTRACT SALES

This account is credited for medical records transcript and abstract fees.

5710 OTHER COMMISSIONS

Commissions earned by the hospital, other than commissions from coin-operated telephones and vending machines, shall be recorded in this account.

5720 TELEVISION/RADIO RENTALS

This account shall be used to record the revenue from television and radio rentals, when the activity is hospital-conducted.

5730 NON-PATIENT ROOM RENTALS

This account is used to record revenue from room (or cot) rentals charged to non-patients.

5740 MANAGEMENT SERVICES REVENUE

This account shall be credited for revenue earned by providing management services to other organizations (both related and non-related).

5750 DONATED BLOOD

This account reflects the fair market value of blood donated to the hospital.

5760 CHILD CARE SERVICES REVENUE - (EMPLOYEES)

This account reflects revenue obtained for providing day care services to children of employees of the hospital. This may include day care for the employee's ill children.

5770 COMMUNITY HEALTH EDUCATION REVENUE

This account reflects revenue obtained from the provision of health education to people of the community. An example of health education would be a seminar put on by the hospital on a health related topic.

5780 OTHER OPERATING REVENUE

This account shall be credited with other operating revenue not included elsewhere, such as non-patient revenue earned by revenue producing centers.

5781* REINSURANCE RECOVERIES

This account reflects reinsurance recoveries received.

See Accounting for Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), and Other Contracts in Section 1220 and Example of Capitation Accounting Journal Entries in Section 1221.1.

** Reportable even though not a zero-level account.*

SYSTEM OF ACCOUNTS

5782* WORKERS' COMPENSATION REFUNDS

This account reflects revenue from workers' compensation refunds.

5790 TRANSFERS FROM RESTRICTED FUNDS FOR OTHER OPERATING EXPENSES

This account reflects the amounts of transfers from restricted funds to the Unrestricted Fund to match expenses incurred in the current period by the Unrestricted Fund for restricted fund activities.

**Reportable even though not a zero-level account.*

Deductions From Revenue 2410.5

The Accounting and Reporting Manual requires that deductions from revenue be reported on Report page 12 ~~by inpatient, outpatient and~~ by financial classification (e.g., Medicare - *Traditional, Medicare - Managed Care,* Medi-Cal - *Traditional, Medi-Cal - Managed Care,* County Indigent Programs - *Traditional, County Indigent Programs - Managed Care,* ~~Third-Party~~ *Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent,* and Other *Payors*). To accommodate this level of reporting, subclassifications of patient revenue must be applied to the deductions from revenue. (See Section 2230 of this Manual for the subclassifications.)

5800 PROVISION FOR BAD DEBTS

This account shall contain the hospital's periodic estimates of the amounts of accounts and notes receivable that are likely to be credit losses, based on a patient's unwillingness to pay. The estimated amount of bad debts may be based on an experience percentage applied to the balance of accounts receivable or the amount of charges to patients' accounts during the period, or it may be based on a detailed aging and analysis of patients' accounts.

Because hospitals experience different bad debt patterns with various classes or types of patients, it is recommended that the computation of the estimate (provision) take into consideration these differences. Sub-accounts may be established in order to reflect the differences more accurately. Although specific sub-accounts are set forth in this Manual, they are not intended to be exclusive or required. The hospital may use any Provision for Bad Debt sub-accounts which will enable a more accurate estimate of credit losses. Any bad debt recoveries must be netted against this account.

5810 CONTRACTUAL ADJUSTMENTS - MEDICARE

These accounts (Accounts 5810, 5820, and 5850) must be charged with the differential (if any) between the amount, based on the hospital's full established rates, of contractual patients' charges for hospital services which are rendered during the reporting period and are covered by the contract, and the amount received and to be received from third-party agencies in payment of such charges, including adjustments made at year end, based upon Cost Reports submitted.

SYSTEM OF ACCOUNTS

For example if, during the year, a hospital follows the practice of debiting the contractual adjustment account for the amount of the retention on interim payments, the following adjustments would be necessary at year end to properly reflect each Contractual Adjustments account:

1) *The amount of the retention in year-end program accounts receivable must be estimated and reflected in the accounting records by debiting the Contractual Adjustment account (Account 5811) and crediting the appropriate Allowance for Contractual Adjustments account (Account 1042.00).*

2) *The Contractual Adjustments account must be adjusted to reflect cost reimbursement settlement, with the offsetting debit or credit going to the appropriate Receivables from Third-Party Payors account (accounts 1051.00 - 1059.00) or Payable to Third-Party Payors account (accounts 2061.00 - 2069.00).*

Prior period contractual revenue adjustments normally would also be reflected in these accounts rather than in the Fund Balance or Retained Earnings accounts.

Should the hospital receive more than its established rates from an agency, the differential is credited to these accounts.

In any instance, of course, when the difference between a patient's bill and the payment received by the hospital from a third-party agency is recoverable from the patient, the differential is retained in Accounts Receivable until it is paid or until it is deemed to be a bad debt and is written off.

5811 CONTRACTUAL ADJUSTMENTS - MEDICARE - TRADITIONAL*

This account must include all non-managed care contractual adjustments described in account 5810 related to patients covered by Medicare.

5812 CONTRACTUAL ADJUSTMENTS - MEDICARE - MANAGED CARE*

This account must include all contractual adjustments described in account 5810 related to patients covered by managed care plans funded by Medicare. Report Medicare capitation premium revenue separately in account 5960.

5820 CONTRACTUAL ADJUSTMENTS - MEDI-CAL

See description under Account ~~5850~~ *5810.*

5821 CONTRACTUAL ADJUSTMENTS - MEDI-CAL - TRADITIONAL*

This account must include all non-managed care contractual adjustments described in account 5810 related to patients covered by Medi-Cal.

** Reportable even though not a zero-level account.*

SYSTEM OF ACCOUNTS

5822 CONTRACTUAL ADJUSTMENTS - MEDI-CAL - MANAGED CARE*

This account must include all contractual adjustments described in account 5810 related to patients covered by managed care plans funded by Medi-Cal. Report Medi-Cal capitation premium revenue separately in account 5970.

~~5821~~ *5830* DISPROPORTIONANTE SHARE PAYMENTS FOR MEDI-CAL PATIENT DAYS (CREDIT BALANCE)

See Accounting for Medi-Cal Disproportionate Share Payments in Section 1270.

~~5830~~ *5840* CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS

This account must be charged with the differential between the amount based upon the hospital's full established rates and the amount reimbursed for patients covered under Welfare and Institution (W&I) Code Section 17000.

~~5841 CAPITATION PREMIUM REVENUE~~

~~This account must be charged with capitation premium revenue.~~

~~See Example of Capitation Accounting Journal Entries in Section 1221.1.~~

5841 CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS - TRADITIONAL*

This account must be charged with the differential between the amount based upon the hospital's full established rates and the amount reimbursed for patients covered under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or in part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) and/or Realignment Funds for which the hospital renders to the County a bill or other claim for payment.

County Medical Services Program (CMSP) was created for counties with a total population of less than 3,000,000. Under this program the State agrees to administer the CMSP funds. Counties within the population guidelines may elect on an annual basis to have the State administer the program. As administrator, the State is responsible for determining indigency. The fund is controlled in a manner similar to the way the Medi-Cal program functions. Eligible patients are given an identification card that indicates CMSP eligibility. The State reimburses whichever hospital the patient chooses in a patient specific manner. The hospital must account for CMSP patients in the same manner as Medi-Cal patients are accounted for. However, charges and related contractual adjustments are to be recorded using the County Indigent Programs payor category. CMSP is not Medi-Cal.

See Accounting for Realignment Funds in Section 1280.

** Reportable even though not a zero-level account.*

SYSTEM OF ACCOUNTS

*5842** *CONTRACTUAL ADJUSTMENTS - COUNTY INDIGENT PROGRAMS - MANAGED CARE*

This account must be charged with the differential between the amount based upon the hospital's full established rates and the amount reimbursed for patients covered under Welfare and Institution (W&I) Code Section 17000 who are covered by managed care plans funded by a county. Report County Indigent Programs capitation revenue in account 5980.

~~5840~~ *5850* CONTRACTUAL ADJUSTMENTS - ~~HMO/PPO AND OTHER CONTRACTS~~ *OTHER THIRD PARTIES*

See description under Account ~~5850~~ *5810*. ~~Report capitation premium revenue separately in account 5841.~~

*5851** *CONTRACTUAL ADJUSTMENTS - OTHER THIRD PARTIES - TRADITIONAL*

This account must include all other non-managed care contractual adjustments described in account 5810 related to patients covered by third parties other than Medicare, Medi-Cal, or County Indigent Programs.

This account also includes contractual adjustments for Tricare (CHAMPUS) and contractual adjustments for Short-Doyle.

The State created the Short-Doyle program to offset the cost to the county for treating mentally ill patients who otherwise could not afford treatment and are not insured. The hospital must determine if the patient is eligible for the Short-Doyle program by completing and reviewing with the patient the eligibility form referred to as the UMDAP, Uniform Method for Determining Ability to Pay. Hospitals should account for the funds received through the Short-Doyle program as a reduction to this account.

*5852** *CONTRACTUAL ADJUSTMENTS - OTHER THIRD PARTIES - MANAGED CARE*

This account must include all contractual adjustments described in account 5810 related to patients covered by managed care plans except those funded by Medicare, Medi-Cal, or a county. Report Other Third Parties capitation premium revenue separately in account 5990.

~~5850 CONTRACTUAL ADJUSTMENTS - OTHER~~

~~These accounts (Accounts 5810, 5820, 5840 and 5850) must be charged with the differential (if any) between the amount, based on the hospital's full established rates, of contractual patients' charges for hospital services which are rendered during the reporting period and are covered by the contract, and the amount received and to be received from third-party agencies in payment of such charges, including adjustments made at year-end, based upon Cost Reports submitted.~~

** Reportable even though not a zero-level account.*

SYSTEM OF ACCOUNTS

~~For example if, during the year, a hospital follows the practice of debiting the contractual adjustment account for the amount of the retention on interim payments, the following adjustments would be necessary at year-end to properly reflect each Contractual Adjustments account:~~

~~1) The amount of the retention in year-end program accounts receivable must be estimated and reflected in the accounting records by debiting the Contractual Adjustment account (Account 5840) and crediting the appropriate Allowance for Contractual Adjustments account (Account 1048.00).~~

~~2) The Contractual Adjustments account must be adjusted to reflect cost reimbursement settlement, with the offsetting debit or credit going to the appropriate Receivables from Third-Party Payors account (accounts 1051.00 - 1059.00) or Payable to Third-Party Payors account (accounts 2061.00 - 2069.00).~~

~~Prior period contractual revenue adjustments normally would also be reflected in these accounts rather than in the Fund Balance or Retained Earnings accounts.~~

~~Should the hospital receive more than its established rates from an agency, the differential is credited to these accounts.~~

~~In any instance, of course, when the difference between a patient's bill and the payment received by the hospital from a third-party agency is recoverable from the patient, the differential is retained in Accounts Receivable until it is paid or until it is deemed to be a bad debt and is written off.~~

~~5851 Contractual Adjustments - Short-Doyle~~

~~The State created the Short-Doyle program to offset the cost to the county for treating mentally ill patients who otherwise could not afford treatment and are not insured. The hospital must determine if the patient is eligible for the Short-Doyle program by completing and reviewing with the patient the eligibility form referred to as the UMDAP, Uniform Method for Determining Ability to Pay. Hospitals should account for the funds received through the Short-Doyle program as a reduction to this account.~~

~~5852 Contractual Adjustments - Tricare (CHAMPUS)~~

5910 SUPPORT FOR CLINICAL TEACHING (CREDIT BALANCE)

This is State support provided exclusively to the University of California hospitals to offset a portion of the cost of their teaching mission. These funds cover the cost of treating certain cases that provide educational benefit as well as the exploration of current medical technology and techniques. Under no circumstances are these funds to be considered compensation for bad debts.

SYSTEM OF ACCOUNTS

~~5970~~ *5920* POLICY DISCOUNTS

Reductions, in the nature of courtesy allowances and employee discounts, from the hospital's established rates for services rendered should be charged to this account and credited to the appropriate Accounts Receivable account.

~~5980~~ *5930* ADMINISTRATIVE ADJUSTMENTS

This account shall be charged or credited for write-offs of immaterial debit or credit balances in patients' accounts in which the cost of billing or refunding exceeds the amount of the account balance.

~~5990~~ *5940* OTHER DEDUCTIONS FROM REVENUE

Other deductions from revenue which are not included elsewhere should be credited to this account.

Capitation Premium Revenue ***2410.6***

5960 CAPITATION PREMIUM REVENUE - MEDICARE

This account reflects capitation premium revenue related to Medicare managed care. See Example of Capitation Accounting Journal Entries in Section 1221.1.

5970 CAPITATION PREMIUM REVENUE - MEDI-CAL

This account reflects capitation premium revenue related to Medi-Cal managed care. See Example of Capitation Accounting Journal Entries in Section 1221.1.

5980 CAPITATION PREMIUM REVENUE - COUNTY INDIGENT PROGRAMS

This account reflects capitation premium revenue related to County Indigent Programs managed care. See Example of Capitation Accounting Journal Entries in Section 1221.1.

5990 CAPITATION PREMIUM REVENUE - OTHER THIRD PARTIES

This account reflects capitation premium revenue related to managed care other than Medicare, Medi-Cal, or County Indigent Programs. See Example of Capitation Accounting Journal Entries in Section 1221.1.

SYSTEM OF ACCOUNTS

EXPENSE ACCOUNTS **2420**

Daily Hospital Services Expense **2420.1**

Hospitals that are charging separately for services such as telemetry in addition to the normal daily hospital service rate should report that revenue in the functional cost center in which the service was performed.

If the hospital purchases inpatient hospital services from another facility, the entire related expense and revenue must be recorded as Purchased Inpatient Services (Accounts 4900 and 7900).

SYSTEM OF ACCOUNTS

7230 OBSERVATION CARE

Function

Observation Care is a formally organized outpatient service of the hospital, which is provided in unlicensed beds. Patients in this cost center are those who are scheduled to be in and out of the hospital within the same day (or night), and include ambulatory surgery, blood transfusions, observation for shock or drug reaction, and other programs where the procedure or treatment generally requires less than 24 hours. If these services are being provided in a licensed bed, or scatter bed, the associated costs and charges must be reclassified to this unit based on a per diem calculation. The per diem is calculated using general inpatient routine cost per diem times the ~~total number of observation care days. Observation care days are determined by dividing the~~ total number of observation hours of care provided in licensed beds *divided* by 24.

Description

This cost center contains the direct expenses incurred in providing observation care. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Number of Observation Hours

The number of hours the patient is receiving observation care rounded to the nearest hour.

Additional Statistic: Observation Care ~~Visits~~ *Days*

An observation care ~~visit~~ *day* is defined as an appearance of a person in the Observation Care unit, or a person receiving observation care services in a licensed (scatter) bed, regardless of the number of hours each patient spends receiving these services. Count an inpatient observation care ~~visit~~ *day* if the patient is formally admitted directly to the hospital from observation care. Count an outpatient observation care ~~visit~~ *day* if the patient is treated and released from the hospital. Observation care ~~visits~~ *days* must be reported on page 4.2 of the Annual Hospital Disclosure Report.

SYSTEM OF ACCOUNTS

7590 CARDIOLOGY SERVICES

7591 Electrocardiology
7592 Stress Testing
7593 Cardiac Rehabilitation
7594 Holter Monitoring

Function

This cost center operates specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis. Other services performed include holter monitoring and use of a treadmill for stress testing and rehabilitative therapy. Additional activities may include, but are not limited to, the following:

Wheeling portable equipment to patient's bedside; explaining test procedures to patient; operating electrocardiograph equipment; inspecting, testing, and maintaining special equipment; attaching and removing electrodes from patient.

Description

This cost center contains the direct expenses incurred in performing electrocardiographic examinations. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Effective for hospital fiscal years beginning on or after July 1, 1990,~~ Cardiology Relative Values are determined by Relative Value Studies, Inc., and listed in the Manual, "Relative Values for Physicians," ~~July 1996~~ *January 1998* Edition, published by St. Anthony Publishing, Inc. The units to be counted are the Technical Component units which are the Total Component (TC) units less the Professional Component (PC) units. Relative Value Units for unlisted, "RNE" (Relativity Not Established), and "BR" (By Report) procedures must be reasonably estimated on the basis of other comparable procedures or estimated by qualified personnel. The above publication may be obtained from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Suite 200, Reston, VA 22090, (800) 632-0123.

SYSTEM OF ACCOUNTS

7630 RADIOLOGY - DIAGNOSTIC

7631 Angiocardiography
7639 Other Radiology - Diagnostic

Function

This cost center provides diagnostic radiology services as required for the examination and care of patients under the direction of a qualified radiologist. Diagnostic radiology services include the taking, processing, examining, and interpreting of radiographs and fluorographs. This cost center must include costs associated with providing diagnostic services in peripheral and cerebro-vascular laboratories. Additional activities may include, but are not limited to, the following:

Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing diagnostic radiology services. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rental, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Effective for hospital fiscal years beginning on or after July 1, 1990~~, Radiology Relative Values are as determined by Relative Value Studies, Inc. and listed in the Manual, "Relative Values for Physicians," ~~July 1996~~ *January 1998* Edition, published by St. Anthony Publishing, Inc. The units to be counted are the Technical Component units which are the Total Component (TC) units less the Professional Component (PC) units. Relative Value Units for unlisted, "RNE" (Relativity Not Established), and "BR" (By Report) procedures must be reasonably estimated on the basis of other comparable procedures or estimated by qualified personnel. The above publication may be obtained from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Suite 200, Reston, VA 22090, (800) 632-0123.

SYSTEM OF ACCOUNTS

7640 RADIOLOGY - THERAPEUTIC

7641 Chemotherapy
7642 Radiation Therapy
7649 Other Radiology - Therapeutic

Function

This cost center provides therapeutic radiology services as required for the care and treatment of patients under the direction of a qualified radiologist. Therapeutic Radiology services include therapy by radium and radioactive substances. Additional activities may include, but are not limited to, the following:

Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing therapeutic radiology services. Included in these direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Effective for hospital fiscal years beginning on or after July 1, 1990~~, Radiology Relative Values are as determined by Relative Value Studies, Inc. and listed in the Manual, "Relative Values for Physicians," ~~July 1996~~ *January 1998* Edition, published by St. Anthony Publishing, Inc. The units to be counted are the Technical Component units which are the Total Component (TC) units less the Professional Component (PC) units. Relative Value Units for unlisted, "RNE" (Relativity Not Established), and "BR" (By Report) procedures must be reasonably estimated on the basis of other comparable procedures or estimated by qualified personnel. The above publication may be obtained from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Suite 200, Reston, VA 22090, (800) 632-0123.

SYSTEM OF ACCOUNTS

7650 NUCLEAR MEDICINE

7651 Diagnostic
7652 Therapeutic
7653 Therapeutic Radioisotope
7654 Radioactive Implants

Function

This cost center provides diagnosis and treatment by injectable or ingestible radioactive isotopes as required for the care and treatment of patients under the direction of a qualified physician. Additional activities may include, but are not limited to, the following:

Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials.

Description

This cost center contains the direct expenses incurred in providing nuclear medicine services to patients. Included as direct expenses are: salaries and wages, employee benefits, professional fees, purchased services, equipment depreciation/- leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Effective for hospital fiscal years beginning on or after July 1, 1990~~, Nuclear Medicine Relative Values are as determined by Relative Value Studies, Inc. and listed in the Manual, "Relative Values for Physicians," ~~July 1996~~ *January 1998* Edition, published by St. Anthony Publishing, Inc. The units to be counted are the Technical Component units which are the Total Component (TC) units less the Professional Component (PC) units. Relative Value Units for unlisted, "RNE" (Relativity Not Established), and "BR" (By Report) procedures must be reasonably estimated on the basis of other comparable procedures or estimated by qualified personnel. The above publication may be obtained from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Suite 200, Reston, VA 22090, (800) 632-0123.

SYSTEM OF ACCOUNTS

7670 ULTRASONOGRAPHY

Function

This cost center provides diagnostic services using low energy sound waves. This technique is non-invasive. The procedure is performed by a qualified technician and is interpreted by a physician. This excludes cardiac ultrasound which is accounted and reported in echocardiology.

Description

This cost center contains the direct expenses incurred in providing diagnostic ultrasonic services. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/- rentals, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units

~~Effective for hospital fiscal years beginning on or after July 1, 1990~~, Ultrasonography Relative Values are as determined by Relative Value Studies, Inc. and listed in the Manual, "Relative Values for Physicians," ~~July 1996~~ *January 1998* Edition, published by St. Anthony Publishing, Inc. The units to be counted are the Technical Component units which are the Total Component (TC) units less the Professional Component (PC) units. Relative Value Units for unlisted, "RNE" (Relativity Not Established), and "BR" (By Report) procedures must be reasonably estimated on the basis of other comparable procedures or estimated by qualified personnel. The above publication may be obtained from St. Anthony Publishing, Inc., 11410 Isaac Newton Square, Suite 200, Reston, VA 22090, (800) 632-0123.

SYSTEM OF ACCOUNTS

7740 RENAL DIALYSIS

Function

Renal Dialysis is the process of cleaning the blood by the use of an artificial kidney machine or other methods (Hemodialysis) or the introduction of dialysate into the peritoneal cavity where it is left several hours for the purpose of removing body waste products from the blood (peritoneal). Additional activities may include, but are not limited to, the following:

Wheeling portable equipment to patient's bedside; explaining procedures to patient; operating dialysis equipment; inspecting, testing, and maintaining special equipment.

Description

This cost center contains the direct expenses incurred in the Renal Dialysis department. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/-leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Number of Hours of Treatment

The number of hours of treatment shall be the difference between the starting time and the ending time (rounded to the nearest ½ hour) defined as follows: starting time is the time when the physician or paramedic assumes control of the dialysis treatment. Ending time is the time when the physician or paramedic relinquishes control of the dialysis treatment.

Additional Statistic: Number of Renal Dialysis Outpatient Visits

A renal dialysis outpatient visit is counted for each appearance of a renal dialysis outpatient in the hospital for renal dialysis treatment, regardless of the length (number of hours) of treatment.

SYSTEM OF ACCOUNTS

7900 PURCHASED INPATIENT SERVICES

Function

This cost center contains the direct expense incurred as a result of contracting out inpatient services to be performed by other hospitals. ~~All services related to inpatients (including all ancillary services rendered to those patients) performed by other hospitals on a contracting basis are to be recorded as an expense in this cost center.~~ *The purchasing hospital records all expenses for inpatient services (including all ancillary services rendered to those patients) performed by other hospitals (or other health care providers) on an arranged basis related to patients who are not formally admitted as inpatients of the purchasing hospital (See related Manual Sections 1221 and 1250). This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the purchasing hospital. Do not record or report the cost of purchased inpatient services as an offset (debit) to capitation premium revenue.*

Description

This cost center contains the direct expenses incurred as a result of purchasing inpatient services from outside entities as defined above. Included as direct expense is purchased services.

Standard Unit of Measure: Purchased Inpatient Days

Number of patient days of care purchased from another hospital.

SYSTEM OF ACCOUNTS

7950 PURCHASED OUTPATIENT SERVICES

Function

This cost center contains the direct expense incurred as a result of contracting with other hospitals (or other health care providers) to provide outpatient services. The purchasing hospital records all expenses for outpatient services performed by other hospitals (or other health care providers) on an arranged basis related to patients who are not registered as outpatients of the purchasing hospital (See related Manual Sections 1222 and 1250). This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the purchasing hospital. Do not record or report the cost of purchased outpatient services as an offset (debit) to capitation premium revenue.

Description

This cost center contains the direct expenses incurred as a result of purchasing outpatient services from outside entities as defined above. Included as direct expense is purchased services.

Standard Unit of Measure: Not Applicable

SYSTEM OF ACCOUNTS

8420 SECURITY

Function

The Security cost center maintains the safety and well-being of hospital patients, personnel, and visitors while at the hospital's facilities and protects the hospital's facilities.

Description

This cost center shall include the direct expenses incurred in maintaining the safety and well-being of hospital patients, employees, and visitors. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Number of *Hospital* FTE Employees

To calculate the number of hospital full-time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the year and divide by 2,080.

SYSTEM OF ACCOUNTS

Administrative Services **2420.8**

8610 HOSPITAL ADMINISTRATION

Function

Hospital Administration performs overall management and administration of the institution.

Description

This cost center contains the direct expenses associated with the overall management and administration of the institution. Also, expenses which are not assignable to a particular cost center must be included here. Expenses such as corporate development, financial planning and internal audit must be included here. However, care must be taken to ascertain that all costs included in this cost center do not properly belong in a different cost center. Expenses chargeable to hospital administration do not include legal fees incurred in connection with the purchase of property (which must be capitalized), nor fund raising costs which must be included in Public Relations (Account 8630). Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers. Also include in this cost center assessments paid to the Office of Statewide Health Planning and Development.

Standard Unit of Measure: Number of *Hospital* FTE Employees

To calculate the number of *hospital* full-time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the year and divide by 2,080.

SYSTEM OF ACCOUNTS

8640 MANAGEMENT ENGINEERING

Function

Management Engineering assists hospital administrators in their managerial function. The management engineer performs a wide variety of services, such as charting the flow of patients through the daily service wards and projecting average daily census for budgetary purposes.

Description

This cost center contains the direct expenses incurred by the management engineering function. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/-leases/rentals, other direct expenses, and transfers.

Standard Unit of Measure: Number of *Hospital* FTE Employees

To calculate the number of *hospital* full-time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the year and divide by 2,080.

SYSTEM OF ACCOUNTS

8660 EMPLOYEE HEALTH SERVICES

Function

The overall management and administration of medical services to employees including scheduling of visits, record-keeping relative to employee visits, and pre-employment and post-illness employee physicals is performed by this cost center.

Description

This cost center shall contain the direct expenses incurred in operating an employee health services office or program. Included as direct expenses are: salaries and wages, employee benefits, professional fees, supplies, purchased services, equipment depreciation/leases/rentals, other direct expenses, and transfers. However, the discounts allowed employees for medical services and supplies provided by the hospital must not be included in this cost center, but must be recorded in the Policy Discounts account (Account 5970).

Standard Unit of Measure: Number of *Hospital* FTE Employees

To calculate the number of *hospital* full-time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the year and divide by 2,080.

SYSTEM OF ACCOUNTS

8820 LEASES AND RENTALS

8821 Leases and Rentals - Buildings
8822 Leases and Rentals - *Fixed* Equipment

Function

Leases and Rentals is a center for the recording of leases and rental expenses relating to all buildings, leasehold improvements, and fixed ~~assets~~ *equipment*.

Description

This cost center contains all lease and rental expenses relating to buildings, leasehold improvements, and fixed ~~assets~~ *equipment*. The cost of *major and minor moveable* equipment leases and rentals must be charged to the using cost center.

Standard Unit of Measure: Number of Square Feet Leased

Leased square feet is defined as the total leased floor areas of the plant, including common areas (hallways, stairways, elevators, lobbies, closets, etc.) leased by the hospital.

SYSTEM OF ACCOUNTS

8880 EMPLOYEE BENEFITS (NON-PAYROLL RELATED)

Function

This center is used to record all employee benefits except payroll-related benefits and other benefits which can be specifically identified as belonging to a particular cost center. An example would be the cost of providing day care for children of employees.

Description

This cost center contains all employee benefits expense except payroll-related benefits and other benefits which can be specifically identified as belonging to a particular cost center. FICA, SUI, vacation, holiday and sick leave, group health insurance, group life insurance, pension and retirement, and worker's compensation insurance would not be included in this cost center. These items shall be included in the direct expense of the using cost center.

Standard Unit of Measure: Number of *Hospital* FTE Employees

To calculate the number of hospital full-time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the reporting period and divide by 2,080.

SYSTEM OF ACCOUNTS

8890 OTHER UNASSIGNED COSTS

8891 Amortization - Intangible Assets

Function

This cost center contains the direct expense incurred for services other than those required to be included in other specific cost centers.

Description

This cost center contains the direct expenses incurred for other costs as defined above. Examples include, amortization of intangible assets, loss on stolen inventory/equipment, loss on litigation, and inventory obsolescence/breakage.

Standard Unit of Measure: Not Applicable

SYSTEM OF ACCOUNTS

9400 OTHER NON-OPERATING REVENUE

This includes all other non-operating revenue not recorded elsewhere.

9510 PHYSICIANS' OFFICES AND OTHER RENTALS - EXPENSE

This includes expenses related to space owned by the hospital that is rented to others, excluding the Medical Office Building.

9520 MEDICAL OFFICE BUILDING EXPENSE

This includes expenses related to a hospital owned Medical Office Building (off-site).

9530 CHILD CARE SERVICES EXPENSE (NON-EMPLOYEES)

Expense incurred for providing day care services to children of non-employees of the hospital. This may include day care for ill children.

9540 FAMILY HOUSING EXPENSE

This includes the cost of providing families of patients a place to stay. It also includes the administrative costs of the program.

9550 RETAIL OPERATIONS - EXPENSE

An example would be an off-site drug store/pharmacy or in-house gift shop that serves the general public rather than patients in the hospital.

9800 OTHER NON-OPERATING EXPENSE

9900 PROVISION FOR INCOME TAXES

~~9701~~ *9901* Federal - current
~~9702~~ *9902* Federal - deferred
~~9703~~ *9903* State - current
~~9794~~ *9904* State - deferred

9920 EXTRAORDINARY ITEMS

An extraordinary item is an event that is unusual and infrequent in occurrence.

SYSTEM OF ACCOUNTS

SUBCLASSIFICATION OF PATIENT SERVICES REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE 2430

The following provides definitions or references to other chapter sections within this Manual that define items shown in the chart at Section 2230 of the Manual.

Financial Status.

Digit

~~0.~~ *.00 and .40* *Traditional* Self-pay - a patient who is not covered by any type of coverage, but has the ability to pay for services.

~~1.~~ ~~HMO/PPO Contracts - these are patients who belong to groups (HMOs or PPOs) that have a contractual relationship with the hospital. Includes HMOs with managed care contracts funded by Medicare and Medi-Cal.~~

~~2.~~ *.02 and .42* ~~Commercial Insurance~~ *Traditional Private Coverage* - these are patients who have their own insurance company who typically pay on a percentage of charges. The hospital does not have a contractual relationship with the insurance company.

~~3.~~ *.03 and .43* *Traditional* Workers' Compensation - these are patients who are covered under the Workers' Compensation Program. The hospital can only collect on the bill from Workers' Compensation and not from the patient. *Does not include patients who are covered by an managed care plan funded by Workers' Compensation.*

~~4.~~ *.04 and .44* *Traditional* Medicare - patients covered under the Social Security Amendments of 1965. These patients are primarily the aged and needy. Does not include patients who are covered by ~~an HMO~~ *a managed care plan* that is funded by Medicare.

~~5.~~ *.05 and .45* *Traditional* Medi-Cal - a patient in this classification is one who qualified as needy under state laws. Does not include patients who are covered by ~~an HMO~~ *a managed care plan* that is funded by Medi-Cal.

~~6.~~ *.06 and .46* ~~Short-Doyle - see description of this program in Section 2410.5 of this Manual under the account description for Account 5851 - Contractual Adjustments - Short-Doyle.~~
Traditional Other Government - patients who are covered by government programs not listed in any other financial status, such as Short-Doyle and Tricare (CHAMPUS). See the description of the Short-Doyle program in Section 2410.5 of this Manual under the description for account 5851.

~~7.~~ *.07 and .47* *Traditional* County Indigent Programs - see description of this program in Section 2410.5 of this Manual under the account descriptions for Account ~~5830~~ *5841* - Contractual Adjustments - County Indigent Programs -*Traditional*.

SYSTEM OF ACCOUNTS

~~8.~~ *.08 and .48* ~~Charity - see description of charity care in Section 1400 of this Manual.~~
Other Indigent - indigent patients, excluding those recorded in the County Indigent Programs category and including those who are being provided charity care by the hospital.

~~9.~~ *.09 and .49* Other - all other financial classes not covered above, *except managed are patients.*

.12 and .52 *Private Coverage Managed Care - patients covered by managed care plans (HMO's, PPO's, EPO's or EPO's with Point of Service option). Does not include managed care plans funded by Medicare, Medi-Cal, a county, or Worker's Compensation.*

.13 and .53 *Worker's Compensation Managed Care - patients covered by the Workers' Compensation Program who are enrolled in a managed care plan funded by Worker's Compensation.*

.14 and .54 *Medicare Managed Care - patients covered under the Social Security Amendments of 1965 who are enrolled in a managed care plan funded by Medicare.*

.15 and .55 *Medi-Cal Managed Care - patients who are qualified as need by state laws and covered by a managed care plan funded by Medi-Cal.*

.17 and .57 *County Indigent Programs Managed Care - patients covered under Welfare and Institutions (W&I) Code Section 17000 who are enrolled in a managed care plan funded by a county.*

SYSTEM OF ACCOUNTS

Job Title	Natural Account Number
Histopathologist	.00
Home Care Aide	.04
Home Health Aide	.04
Hospital Guide	.09
Housekeeping Aide	.06
Housekeeping Attendant	.06
Housekeeping Crew Leader	.00
Incinerator Person	.06
Industrial Engineer	.01
Instructor	.01
Insurance Clerk	.05
Internal Auditor	.01
Interviewer	.05
Invoice Control Clerk	.05
Job Analyst	.01
Key-entry Operator	.05
Laboratory Aide	.09
Library Assistant	.05
Licensed Psychiatric Technician	*.03*
Licensed Vocational Nurse	.03
Mail Clerk	.05
Maintenance Helper	.06
Maintenance Mechanic	.06
Manager	.00
Manual-Arts Therapist	.01
Marker-Sorter	.06
Medic	.08
Medical Assistant	.01
Medical Illustrator	.01
Medical Laboratory Assistant	.09
Medical Librarian	.01
Medical Photographer	.01
Medical Record Clerk	.05
Medical Record Librarian	.00
Medical Record Technician	.01
Medical Secretary	.05
Medical Stenographer	.05
Medical Technologist	.01
Medical Transcriptionist	.01
Mental Health Worker	.01
Messenger	.05

STATISTICS

GENERAL SERVICES

Printing and Duplicating	Number of Reams of Paper Used	8310
Non-Patient Food Services	Equivalent Number of Meals Served	8330
Dietary	Number of Patients Meals	8340
Laundry and Linen	Number of Dry and Clean Pounds Processed	8350
Social Work Services	Number of Personal Contacts	8360
Central Service and Supply	Number of Central Services and Supplies Adjusted Inpatient Days	8380
Pharmacy	Number of Pharmacy Adjusted Inpatient Days	8390
Purchasing and Stores	$1,000 of Gross Non-capitalized Purchases	8400
Grounds	Number of Square Feet of Ground Space	8410
Security	Number of *Hospital* FTE Employees	8420
Parking	Number of Square Feet of Parking Area	8430
Housekeeping	Number of Square Feet Serviced	8440
Plant Operations	Number of Gross Square Feet	8450
Plant Maintenance	Number of Gross Square Feet	8460
Communications	Average Number of Hospital Employees	8470
Data Processing	$1,000 of Gross Patient Revenue	8480

FISCAL SERVICES

General Accounting	Average Number of Hospital Employees	8510
Patient Accounting	$1,000 of Gross Patient Revenue	8530
Credit and Collection	$1,000 of Gross Patient Revenue	8550
Admitting	Number of Admissions	8560
Outpatient Registration	Number of Registrations	8570

STATISTICS

ADMINISTRATIVE SERVICES

Hospital Administration	Number of *Hospital* FTE Employees	8610
Governing Board Expense	$1,000 of Total Operating Revenue	8620
Public Relations	$1,000 of Total Operating Revenue	8630
Management Engineering	Number of *Hospital* FTE Employees	8640
Personnel	Average Number of Hospital Employees	8650
Employee Health Services	Number of *Hospital* FTE Employees	8660
Auxiliary Groups	Number of Volunteer Hours	8670
Chaplaincy Services	Number of Patient (Census) Days	8680
Medical Library	Number of Physicians on Active Staff	8690
Medical Records	Number of Adjusted Patient Days	8700
Medical Staff Administration	Number of Physicians on Active Staff	8710
Nursing Administration	Average Number of Nursing Service Personnel	8720
Inservice Education - Nursing	Number of Hours of Nursing Inservice Education	8740
Utilization Management	Number of Admissions	8750
Community Health Education	Number of Participants	8770

UNASSIGNED COSTS

Depreciation and Amortization	Number of Gross Square Feet Owned	8810
Leases and Rentals	Number of Gross Square Feet Leased	8820
Insurance - Hospital and Professional Malpractice	$1,000 of Gross Patient Revenue	8830
Insurance - Other	Number of Gross Square Feet	8840
Licenses and Taxes (Other than on Income)	Number of Gross Square Feet	8850
Interest - Working Capital	$1,000 of Gross Patient Revenue	8860
Interest - Other	Number of Gross Square Feet	8870
Employee Benefits (Non-Payroll)	Number of *Hospital* FTE Employees	8880

STATISTICS

patients who use the emergency room for care. An Emergency Services Visit is counted for each appearance of a patient in an emergency services unit (medical or psychiatric) of the hospital. Count an INPATIENT EMERGENCY SERVICES VISIT if the patient is formally admitted to the hospital from Emergency Services. Count an OUTPATIENT EMERGENCY SERVICES VISIT if the patient is treated and released from the hospital.

Do not count additional Emergency Services visits for visits by emergency patients to ancillary cost centers such as Laboratory or Radiology.

An OUTPATIENT AMBULATORY SURGERY VISIT is counted for each patient undergoing outpatient surgery, regardless of the number of surgical procedures performed while the patient was in an operating or procedure room. Count, by payor, one outpatient surgery visit for each outpatient surgery related to Satellite Ambulatory Surgery Center, Surgery and Recovery Services, and Ambulatory Surgery Services; and include these outpatient surgery visits with Total Outpatient Visits on page 4.2 of the Annual Hospital Disclosure Report and on the Quarterly Financial and Utilization Report. [NOTE: Even though outpatient surgery visits are not a separate, reportable data item on the annual disclosure report, that are still to be included on the count of outpatient visits.

A RENAL DIALYSIS OUTPATIENT VISIT is counted for each appearance of a renal dialysis outpatient in the hospital for renal dialysis treatment, regardless of the length (number of hours) of treatment.

An OBSERVATION CARE ~~VISIT~~ *DAY* relates to the provision of medical or nursing care to patients who are scheduled to be in and out of the hospital within the same day (or night). The treatment received (e.g., receiving blood transfusions or being observed for drug reactions) generally requires less than 24 hours of care. An Observation Care ~~visit~~ *day* is counted for each appearance of a patient in the Observation Care unit, or for each patient receiving observation care in a licensed (scatter) bed, regardless of the number of hours spent receiving those services. Count an INPATIENT OBSERVATION CARE ~~VISIT~~ *DAY* if the patient is formally admitted to the hospital following the visit. Count an OUTPATIENT OBSERVATION CARE ~~VISIT~~ *DAY* for each patient receiving observation care services on an outpatient basis. This includes patients remaining in an Observation Care unit, or patients who continue to receive observation care services for more than 24 hours, but are <u>not</u> formally admitted as inpatients.

A PARTIAL HOSPITALIZATION - PSYCHIATRIC VISIT relates to the provision of care to psychiatric patients who come to the hospital during the day and return home at night, or spend the night at the hospital and the day away from the hospital. A Partial Hospitalization - Psychiatric visit is counted for each appearance of a patient in a formally organized Psychiatric Day and Night Care program of the hospital. Multiple services performed in the Psychiatric Day and Night Care unit during a single appearance, (e.g., encounters with two or more psychiatrists, two or more occasions of service, any combination of one or more encounters and occasions of service) are counted as one visit.

INTERPRETATIONS

TOBACCO TAX FUNDS RECEIVED BY NON-COUNTY HOSPITALS 6101

Query:

How are Tobacco Tax funds calculated and distributed to hospitals, and how should non-county hospitals account and report Tobacco Tax funds that are received from the county? Does it make a difference if the amount of such funds is based on a percentage of uncompensated care costs within the county or is negotiated between the non-county hospital and the county?

Answer:

Every April 15, the Office's quarterly report database for the previous calendar year is "frozen" and necessary data items are extracted to compute each hospital's uncompensated care costs. The following allocations are then made:

Each county's percentage of statewide uncompensated care costs is calculated to determine their portion of the Tobacco Tax funds appropriated from the Hospital Services account. Each county then splits their allocation between county and non-county hospitals based on their respective percentage of county uncompensated care costs. The amount allocated to non-county hospitals is then split - 50% is distributed to non-county hospitals based on their proportion of the county's uncompensated care costs ("formula dollars"), and the other 50% is distributed to non-county hospitals based on negotiations between the county and the non-county hospital ("discretionary funds").

The accounting and reporting requirements for "formula dollars" and "discretionary funds" received by non-county hospitals are the same under most circumstances. Both "formula dollars" and "discretionary funds" are generally used to offset the cost of providing care to indigent patients who are unable to pay for rendered services and who are **not** the responsibility of the county. As a result, the amounts are to be accounted for as a debit to Cash (Account 1000), or a receivable account, and a credit to Restricted Donations and Subsidies for Indigent Care (Account 5880). The patient's accounts receivable is to be written-off to Charity - Other (Account 5870), and related revenue and utilization statistics are to be recorded in the Other ~~Payors~~ *Indigent* payor category.

In some instances, a non-county hospital may negotiate with the county to receive "discretionary funds" in exchange for providing medical services to patients who are the responsibility of the county. In such cases, the accounting entry would be a debit to Cash (Account 1000), or a receivable account, and a credit to Contractual Adjustments - County Indigent Programs - *Traditional* (Account ~~5830~~ *5841*). Related revenue and utilization statistics are to be recorded in the County Indigent Programs payor category.

INTERPRETATIONS

SB 1255 MEDI-CAL DISPROPORTIONATE SHARE PROGRAM 6103

Query:

Our hospital is eligible to participate in the SB 1255 Disproportionate Share Program and has successfully negotiated with the California Medical Assistance Commission (CMAC) to receive SB 1255 payments. We agreed to receive a specified rate per paid Medi-Cal patient day for a specified time period, up to a total dollar amount. We will receive lump-sum periodic payments from the Department of Health Services instead of being paid through the Medi-Cal fiscal intermediary. How are these SB 1255 payments to be accounted and reported?

Answer:

Since SB 1255 payments are considered supplemental payments for services provided to Medi-Cal patients, they are to be included in net Medi-Cal inpatient revenue by crediting Medi-Cal Contractual Adjustments. Record the gross amount received as a debit to Cash (Account 1000), or a receivable account, and a credit to Contractual Adjustments - Medi-Cal - *Traditional* (Account ~~5820~~ *5821*). If a portion of the SB 1255 payments are transferred back to a related public entity, record the transaction as a debit to Fund Balance (Account 2310) and a credit to Cash (Account 1000). Report such transfers as a reduction to the Fund Balance on Report Page 7, Statement of Changes in Equity.

Do **not** record and report SB 1255 payments in Disproportionate Share Payments for Medi-Cal Patient Days (Account ~~5821~~ *5830*). This account is to be used only for recording and reporting SB 855 disproportionate share payments. See Section 1270 of the Manual for information regarding the SB 855 Disproportionate Share Program.

REPORTING REQUIREMENTS

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REPORTING REQUIREMENTS

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REPORTING REQUIREMENTS

PREFACE 7001

Section ~~443.31~~ *128735* of the Health and Safety Code requires hospitals to report annually specified financial and statistical data on forms specified by this Office. The forms included within this chapter represent the reporting requirements of each hospital to this Office.

Section ~~90741~~ *97041*, Title 22, of the California Code of Regulations~~, was amended in October 1993 to require~~ *requires* all hospitals to submit the Office's Annual Hospital Disclosure Report in a standard electronic format, as defined by the Office, rather than using hard-copy report forms. ~~Effective with annual reporting periods ending on or after June 30, 1994, hospitals must submit their annual disclosure report on PC diskette.~~ The software used for electronic filing must be in a standard electronic format, as defined by the Office, and pre-approved by the Office. Hospitals may elect to use approved software developed by a third party or by the hospital. *After completing annual disclosure reports using Office-approved report preparation software, hospitals must either 1) submit their annual disclosure reports on PC diskettes, or 2) transmit their annual disclosure reports by modem to the Office's Bulletin Board System (BBS).* Please contact the Office of Statewide Health Planning and Development at (916) 323-0875 to receive a list of approved third party *report preparation* software vendors*, or to receive the software for transmitting annual disclosure reports generated by Office-approved software by modem to the Office's BBS.*

Although flexibility has been allowed in the accounting system for each hospital, the reporting requirements, as presented in the forms and the instructions thereto, are uniform for all hospitals.

The balance sheet account groupings, indicated in the Chart of Accounts by a fourth digit of zero (i.e., XXX0.XX) must be reported.

All cost and revenue centers having a fourth primary digit of "0", whose functions are performed in the hospital, must be reported. As noted in Sections 2120, 2130 and 2140 certain non-zero level accounts are reportable accounts. As noted in the Cost Finding chapter of this Manual, certain reclassifications will be necessary if a hospital performs or records the required revenue and cost center functions in other cost centers. For example, if all laboratory functions are performed in one cost center and because the costs, revenue, and statistics of that cost center are not segregated into the functional centers required in the Manual, a reclassification of the cost center's expense, revenue, and statistics will be necessary.

Reports must be submitted by all hospitals (Division 1, Part 1.8, Section 443.31 of the Health and Safety Code) for all annual accounting periods.

A report must be completed and submitted annually to this Office within four months after the close of the hospital's annual accounting period. In order to be considered complete, all required report pages must be correctly filled out, in accordance with instructions. Any hospital which does not file all report pages completed as required is liable for civil penalty of one hundred dollars ($100) a day for each day the filing of the disclosure report with the Office is delayed, considering all extension days granted by the Director of the Office.

REPORTING REQUIREMENTS

LIST OF REPORTING FORMS 7010

For report periods ending on or before June 29, 2000:

Form No.	Report Page	Title	Preparation Sequence
CHC 7041 h-1	0	General Information and Certification	23
CHC 7041 h-2	1	Hospital Description	12
CHC 7041 h-3	2	Services Inventory	13
CHC 7041 h-4	3.1-3.4	Related Hospital Information	14
CHC 7041 h-5	4.1	Patient Census Statistics	15
CHC 7041 h-5	4.2	Ambulatory, Ancillary and Other Utilization Statistics	16
CHC 7041 a-1	5	Balance Sheet - Unrestricted Fund	17
CHC 7041 a-1	5.1	Supplemental Long-Term Debt Information	18
CHC 7041 a-3	5.2	Statement of Changes in Property, Plant, Equipment Balances	19
CHC 7041 b-1	6	Balance Sheet - Restricted Funds	20
CHC 7041 c-1	7	Statement of Changes in Equity	21
CHC 7041 d-1	8	Statement of Income - Unrestricted Fund	11
CHC 7041 d-1	8.1	Statement of Income - Unrestricted Fund (Non-Operating Revenue and Expense)	10
CHC 7041 e-1	9	Statement of Cash Flows - Unrestricted Fund	22
CHC 7041 d-3	12	Supplemental Patient Revenue Information	1
CHC 7041 d-5	14	Supplemental Other Operating Revenue Information	2
CHC 7041 d-6	15	Reclassification Worksheet - Physician and Student Compensation - Patient Revenue Producing Centers	3
CHC 7041 d-7	16	Reclassification Worksheet - Physician and Student Compensation - Non-Revenue Producing Centers	3
CHC 7041 d-8	17	Trial Balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers	4
CHC 7041 d-9	18	Trial Balance Worksheet and Supplemental Expense Information - Non-Revenue Producing Centers	4
CHC 7041 g-2	19a	Cost Allocation - Statistical Basis Short Form	7
CHC 7041 g-1	19	Cost Allocation - Statistical Basis	8
CHC 7041 f-1	20	Cost Allocation	7
CHC 7041 f-1	20a	Cost Allocation Short Form	9

REPORTING REQUIREMENTS

Form No.	Report Page	Title	Preparation Sequence
CHC 7041 h-6	21	Detail of Direct Payroll Costs - Patient Revenue Producing Centers	5
CHC 7041 h-7	21.1	Detail of Direct Contracted Costs - Patient Revenue Producing Centers	6
CHC 7041 h-8	22	Detail of Direct Payroll Costs - Non-Revenue Producing Centers	5
CHC 7041 h-9	22.1	Detail of Direct Contracted Costs - Non-Revenue Producing Centers	6

For report periods ending on or after June 30, 2000:

Form No.	*Report Page*	*Title*	*Preparation Sequence*
CHC 7041 h-1	*0*	*General Information and Certification*	*22*
CHC 7041 h-2	*1*	*Hospital Description*	*11*
CHC 7041 h-3	*2*	*Services Inventory*	*12*
CHC 7041 h-4	*3.1-3.4*	*Related Hospital Information*	*13*
CHC 7041 h-5	*4*	*Patient Utilization Statistics*	*14*
CHC 7041 h-5	*4.1*	*Patient Census Statistics by Payor*	*15*
CHC 7041 a-1	*5*	*Balance Sheet - Unrestricted Fund*	*16*
CHC 7041 a-1	*5.1*	*Supplemental Long-Term Debt Information*	*17*
CHC 7041 a-3	*5.2*	*Statement of Changes in Property, Plant, Equipment Balances*	*18*
CHC 7041 b-1	*6*	*Balance Sheet - Restricted Funds*	*19*
CHC 7041 c-1	*7*	*Statement of Changes in Equity*	*20*
CHC 7041 d-1	*8*	*Statement of Income - Unrestricted Fund*	*10*
CHC 7041 e-1	*9*	*Statement of Cash Flows - Unrestricted Fund*	*21*
CHC 7041 d-3	*12*	*Supplemental Patient Revenue Information*	*1*
CHC 7041 d-5	*14*	*Supplemental Other Operating Revenue Information*	*2*
CHC 7041 d-6	*15*	*Reclassification Worksheet - Physician and Student Compensation - Patient Revenue Producing Centers*	*3*
CHC 7041 d-7	*16*	*Reclassification Worksheet - Physician and Student Compensation - Non-Revenue Producing Centers*	*3*
CHC 7041 d-8	*17*	*Trial Balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers*	*4*
CHC 7041 d-9	*18*	*Trial Balance Worksheet and Supplemental Expense Information - Non-Revenue Producing Centers*	*4*

REPORTING REQUIREMENTS

Form No.	*Report Page*	*Title*	*Preparation Sequence*
CHC 7041 g-2	*19a*	*Cost Allocation - Statistical Basis Short Form*	*7*
CHC 7041 g-1	*19*	*Cost Allocation - Statistical Basis*	*8*
CHC 7041 f-1	*20*	*Cost Allocation*	*7*
CHC 7041 f-1	*20a*	*Cost Allocation Short Form*	*9*
CHC 7041 h-6	*21*	*Detail of Direct Payroll Costs - Patient Revenue Producing Centers*	*5*
CHC 7041 h-7	*21.1*	*Detail of Direct Contracted Costs - Patient Revenue Producing Centers*	*6*
CHC 7041 h-8	*22*	*Detail of Direct Payroll Costs - Non-Revenue Producing Centers*	*5*
CHC 7041 h-9	*22.1*	*Detail of Direct Contracted Costs - Non-Revenue Producing Centers*	*6*

REPORTING REQUIREMENTS

INSTRUCTIONS FOR COMPLETING REPORTING FORMS 7020

These instructions relate to the Hospital Disclosure Report for the reporting periods ending on or after December 31, 1992.

Reports must be submitted by all hospitals licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

The following rules apply to completing and submitting the Hospital Disclosure Report:

1. One original and one legible copy of the disclosure report must be submitted to the Office within four months after the end of each reporting period by the organization which operated the facility during the reporting period. The reporting period ends: (a) at the close of the hospital's annual accounting period fiscal year, (b) on the last day of patient care when the hospital no longer accepts patients, (c) on the last day of patient care at the old plant when the hospital closes to relocate to a new plant, or (d) on the last day of licensure of the entity relinquishing the license when there is a change in licensee.

   ~~Effective with reporting periods ending on or after June 30, 1994, hospitals~~ *Hospitals* must ~~submit~~ *prepare* annual disclosure reports ~~on PC diskette~~ *using the latest Office-approved report preparation software*, rather than using hard-copy report forms. *Hospitals may elect to submit their annual disclosure reports generated by Office-approved report preparation software either 1) on PC diskettes or 2) by transmitting them by modem to the Office's Bulletin Board System (BBS).* Hospitals which are unable to meet the Office's electronic reporting requirements must obtain written approval from the Office to use hard-copy report forms. When submitting your disclosure report using one of the Office-approved PC diskette systems, send only one copy of the appropriate diskette and two signed copies of the system-produced certification. You do not need to send a copy of the system-generated facsimile report. *When transmitting your annual disclosure report by modem to the Office's BBS, you must still mail a copy of the signed certification produced by the report preparation software. If you have received written approval from the Office to use hard-copy report forms, send the original and one copy of the completed report.*

   The licensee is responsible for reporting for the entire period of licensure, even if there is an agreement between the parties on a change in licensee for the new licensee to operate the facility prior to the new license being effective. However, a reporting modification would be considered if a new licensee wants to report for a period which begins prior to the effective date of the

REPORTING REQUIREMENTS

Reclassification, as defined in Chapter 5000, of revenues and expenses, may be necessary to achieve the uniform disclosure reporting requirements of this Manual. Revenue and statistics reclassifications must be separated as to inpatient and outpatient and as to ~~payor (Medicare, Medi-Cal, County Indigent Programs, Third Parties, and Other Payors)~~ *payer (See Manual Section 7020.2 for a list of the payer categories)*. Outpatient statistics for ancillary centers must be reclassified by outpatient classification to meet the requirements of report page 4.2. Expense (cost center) reclassifications must be separated into eight major natural classifications: salaries (.00-.09), employee benefits (.10-.19); professional fees (.20-.29); supplies (.30-.59); purchased services (.60-.69); depreciation (.71-.74): leases and rentals (.75-.76); and other direct expenses (.77-.90).

Reclassifications will usually be made for one of three reasons:

A. To achieve the required level of reporting. If the hospital provides services which are required to be reported separately, and these services are combined with others, a reclassification will be required. An example of this type would be where all laboratories are grouped into one cost center. The Manual requires separate reporting for clinical, pathological, and pulmonary function labs. Therefore, a reclassification to achieve the required level of reporting is necessary.

B. To correct for dislocated patients. Revenue, statistics, and expenses associated with a particular type of patient (pediatrics acute, obstetrics acute, medical/surgical acute, etc.) must be reported in the proper functional cost center irrespective of the actual location and treatment of the patient. For example, acute patients are occasionally placed in an intensive care bed when acute beds are filled to capacity. The expenses and possibly the revenue and statistics would be reclassified to correct for these dislocated patients.

C. To correct for dislocated functions. Revenue, statistics and expenses associated with a particular function must be reported in the proper cost center as defined in this Manual. For example, if the pharmacy administers I.V. solutions to patients (a function of the appropriate nursing cost center as defined in Section 2420.1), a reclassification would be required.

NOTE: Reclassifications must not be used for posting trial balance amounts. Any expenses, revenue, and units of service which must be added to the trial balance figures must be entered on the books of the hospital.

REPORTING REQUIREMENTS

Page 12 SUPPLEMENTAL PATIENT REVENUE INFORMATION 7020.2

For report periods ending on or before June 29, 2000, complete report page 12 following the instructions specified in Instruction No. 1. For report periods ending on or after June 30, 2000, complete report page 12 following the instructions specified in Instruction No. 2.

Instruction No. 1 (Report Periods ending on or before June 29, 2000)

This page requires that gross inpatient and outpatient revenue be reported by revenue center by revenue source, Medicare, Medi-Cal, County Indigent Programs Third-Parties, and Other Payors. Deductions from revenue must be reported by Medicare, County Indigent Programs, Third-Parties, and Other Payors by inpatient and outpatient on page 12. Total Medi-Cal deductions from revenue must also be reported. The hospital must report revenue for each line (revenue center) on page 12 if there was revenue produced for the functions listed.

The hospital may have combined certain accounts (functions), but for reporting purposes each must be reported separately. As an example, Coronary Care revenue may have been combined with Medical/Surgical Intensive Care revenue on the books, however, for reporting purposes, the revenue for each must be separately reported. The revenue must be reclassified prior to reporting on page 12. A separate worksheet will be necessary to reclassify any applicable amounts. This worksheet need not be submitted with the disclosure report to the Office but must be maintained as part of the hospital's records.

All hospitals, including inclusive rate hospitals, must complete steps 1 through 33, as applicable. Prior to completing the following steps, inclusive rate hospitals must reclassify revenue from the hospital's revenue service categories to the standard revenue centers on page 12 using the cost ratios developed by cost studies performed in establishing the inclusive rates. Worksheets supporting such reclassifications need not be submitted but must be maintained as a part of the hospital's records. Please refer to Sections 2230 and 2430 of this Manual for subclassifications of patient service revenue accounts and deductions from revenue. For reporting purposes the following chart indicates the groupings of subclassification of revenue and deductions for revenue by payor category.

Payor	Financial Status Classification
Medicare	.X4
Medi-Cal	.X5
County Indigent Programs	.X7
Third-Parties	.X1, .X2, .X3, and .X6
Other Payors	.X0, .X8 and .X9

REPORTING REQUIREMENTS

Instruction No. 2 (Report Periods ending on or after June 30, 2000)

This page requires that gross inpatient and outpatient revenue be reported by revenue center by revenue source, Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors. Deductions from revenue must be reported by Medicare - Traditional, County Indigent Programs - Traditional, Other Third Parties - Traditional, Other Indigent, and Other Payors by inpatient and outpatient on page 12. Also, total deductions from revenue must be reported by Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Managed Care, and Other Third Parties - Managed Care on page 12. The hospital must report revenue for each line (revenue center) on page 12 if there was revenue produced for the functions listed.

The hospital may have combined certain accounts (functions), but for reporting purposes each must be reported separately. As an example, Coronary Care revenue may have been combined with Medical/Surgical Intensive Care revenue on the books, however, for reporting purposes, the revenue for each must be separately reported. The revenue must be reclassified prior to reporting on page 12. A separate worksheet will be necessary to reclassify any applicable amounts. This worksheet need not be submitted with the disclosure report to the Office but must be maintained as part of the hospital's records.

All hospitals, including inclusive rate hospitals, must complete steps 1 through 48, as applicable. Prior to completing the following steps, inclusive rate hospitals must reclassify revenue from the hospital's revenue service categories to the standard revenue centers on page 12 using the cost ratios developed by cost studies performed in establishing the inclusive rates. Worksheets supporting such reclassifications need not be submitted but must be maintained as a part of the hospital's records. Please refer to Sections 2230 and 2430 of this Manual for subclassifications of patient service revenue accounts and deductions from revenue. For reporting purposes the following chart indicates the groupings of subclassification of revenue and deductions for revenue by payor category.

Payer	*Financial Status Classification*
Medicare - Traditional	*.04, .44*
Medicare - Managed Care	*.14, .54*
Medi-Cal - Traditional	*.05, .45*
Medi-Cal - Managed Care	*.15, .55*
County Indigent Programs - Traditional	*.07, .47*
County Indigent Programs - Managed Care	*.17, .57*
Other Third Parties - Traditional	*.02,.03, .06, .42, .43, and .46*
Other Third Parties - Managed Care	*.12, .13, .52, .53,*
Other Indigent	*.08, .48*
Other Payors	*.00, .09, .40, .49*

REPORTING REQUIREMENTS

1. *Enter gross Medicare - Traditional inpatient and outpatient revenue (revenue subclassifications .04 and .44) by revenue center, after reclassification, in columns 1 and 3, respectively.*

2. *Enter gross Medicare - Managed Care inpatient and outpatient revenue (revenue subclassifications .14 and .54) by revenue center, after reclassification, in columns 5 and 7, respectively.*

3. *Enter gross Medi-Cal - Traditional inpatient and outpatient revenue (revenue subclassifications .05 and .45) by revenue center, after reclassification, in columns 9 and 11, respectively.*

4. *Enter gross Medi-Cal - Managed Care inpatient and outpatient revenue (revenue subclassifications .15 and .55) by revenue center, after reclassification, in columns 13 and 15, respectively.*

5. *Enter gross County Indigent Programs - Traditional inpatient and outpatient revenue (revenue subclassifications .07 and .47) by revenue center, after reclassification, in columns 17 and 19, respectively.*

6. *Enter gross County Indigent Programs - Managed Care inpatient and outpatient revenue (revenue subclassifications .17 and .57) by revenue center, after reclassification, in columns 21 and 23, respectively.*

7. *Enter Other Third Parties - Traditional inpatient and outpatient gross revenue (revenue subclassifications .02, .03, .06, .42, .43, and .46) by revenue center, after reclassification, in columns 25 and 27, respectively.*

8. *Enter Other Third Parties - Managed Care inpatient and outpatient gross revenue (revenue subclassifications .12, .13, .42, and .43) by revenue center, after reclassification, in columns 29 and 31, respectively.*

9. *Enter Other Indigent inpatient and outpatient gross revenue (revenue subclassifications .08 and .48) by revenue center, after reclassification; in columns 33 and 35.*

10. *Enter Other Payors inpatient and outpatient gross revenue (revenue subclassifications .00, .09, .40, .49) by revenue center, after reclassification; in columns 37 and 39.*

11. *Enter total gross inpatient revenue (sum of columns 1, 5, 9, 13, 17, 21, 25, 29, 33 and 37) by revenue center in column 41.*

12. *Enter total gross outpatient revenue (sum of columns 3, 7, 11, 15, 19, 23, 27, 31, 35, and 39) by revenue center in column 43.*

REPORTING REQUIREMENTS

13. *Enter total gross patient revenue (sum of columns 41 and 43) by revenue center in column 45.*

14. *Total lines 5 through 145 of each daily hospital services column on line 150. Total lines 160 through 220 of each ambulatory services column on line 225. Total lines 230 through 400 of each ancillary services column on line 405. Enter the total of lines 150, 225, and 405 on line 415.*

15. *The total daily hospital services revenue on line 150, column 45, must equal page 8, column 1, line 5.*

16. *The total ambulatory services revenue on line 225, column 45, must equal page 8, column 1, line 10.*

17. *The total ancillary services revenue on line 405, column 45, must equal page 8, column 1, line 15.*

18. *The total patient revenue on line 415, column 45 must equal page 8, column 1, line 30.*

19. *Enter the Provision for Bad Debts (Account 5800 by subclassification, e.g. Account 5800.00 would be recorded in the other payor column) on line 420, columns 1 through, 37.*

20. *Enter the inpatient Medicare - Traditional contractual adjustments (Account 5811.04 - including prior year Medicare cost reimbursement settlements, if any) on line 425, column 1.*

21. *Enter the outpatient Medicare - Traditional contractual adjustments (Account 5811.44 - including prior year Medicare cost reimbursement settlements, if any) on line 425, column 3.*

22. *Enter total Medicare - Managed Care contractual adjustments (Account 5812) on line 425, column 5.*

23. *Enter total Medi-Cal - Traditional contractual adjustments (Accounts 5821.05 and 5821.45 - including prior year Medi-Cal cost reimbursement settlements, if any) on line 425, column 9. This item must equal page 8, column 1, line 320.*

24. *Enter total Medi-Cal - Managed Care contractual adjustments (Account 5822) on line 425, column 13. This item must equal page 8, column 1, line 315.*

25. *Enter the inpatient County Indigent Programs - Traditional contractual adjustments (Account 5841.07) on line 425, column 17.*

26. *Enter the outpatient County Indigent Programs - Traditional contractual adjustments (Account 5841.47) on line 425, column 19.*

REPORTING REQUIREMENTS

27. Enter total County Indigent Programs - Managed Care contractual adjustments (Account 5842) on line 425, column 21.

28. Enter the inpatient Other Third Parties - Traditional contractual adjustments (Accounts 5851.02, 5851.03, and 5851.06) on line 425, column 25.

29. Enter the outpatient Other Third Parties - Traditional contractual adjustments (Accounts 5851.42, 5851.43, and 5851.46) on line 425, column 27.

30. Enter total Other Third Parties - Managed Care contractual adjustments (Account 5852) on line 425, column 29.

31. Enter the total disproportionate share payments for Medi-Cal patient days (Account 5830) in column 9, line 426. This item must equal page 8, column 1, line 325. See Section 1270 of this Manual for more information on Medi-Cal disproportionate share payments.

32. Enter total charity deductions from revenue (combine Accounts 5860 and 5870 by subclassification, e.g. Account 5860.08 would be recorded in the other indigent column) on line 430, columns 1 through 39.

33. Enter total Restricted Donations and Subsidies for Indigent Care (Account 5880 by subclassification, e.g. Account 5880.08 would be recorded in the other indigent column) on line 435, columns 1 through 39.

NOTE: Steps 34 through 37 are to be completed only by the University of California teaching hospitals.

34. Enter the inpatient teaching allowances (Account 5890.09) on line 440, column 37.

35. Enter the outpatient teaching allowances (Account 5890.49) on line 440, column 39.

36. Enter the inpatient support for clinical teaching (Account 5910.09) on line 445, column 37.

37. Enter the outpatient support for clinical teaching (Account 5910.49) on line 445, column 39.

38. Enter total other deductions from revenue (Accounts 5920, 5930, and 5940 by subclassification, e.g. Account 5940.00 would be recorded in the other payor column) on line 450, columns 1 through 39.

39. Enter the sum of lines 420 through 450 on line 455 for each column.

REPORTING REQUIREMENTS

40. Enter total deductions from revenue (sum of columns 1 through 39) for lines 420 through 455 in column 45.

41. Enter total Medicare capitation premium revenue (Account 5960 - including settlements on risk sharing agreements, if any) on line 457, column 5.

42. Enter total Medi-Cal capitation premium revenue (Account 5970 - including settlements on risk sharing agreements, if any) on line 457, column 13.

43. Enter total County Indigent Programs capitation premium revenue (Account 5980 - including settlements on risk sharing agreements, if any) on line 457, column 21.

44. Enter total Other Third Parties capitation premium revenue (Account 5990 - including settlements on risk sharing agreements, if any) on line 457, column 25.

45. Enter total capitation premium revenue (sum of columns 1, 9, 17, and 25) on line 457, column 45.

46. Enter the total net patient revenue on line 460 for each column, by subtracting total deductions from revenue on line 455 from total patient revenue on line 415 then adding capitation premium revenue on line 457.

REPORTING REQUIREMENTS

65	Non-Patient Food Service	Equivalent Number of Meals Served	
70	Dietary	Number of Patients Meals	= P.19, C.9, L.920
75	Laundry and Linen	Number of Dry and Clean Pounds Processed	> P.19, C.10, L.920
80	Social Work Services	Number of Personal Contacts	
90	Central Service and Supply	Number of Central Services and Supplies Adjusted Inpatient Days	= P.4.2, C.1, L.250
95	Pharmacy	Number of Pharmacy Adjusted Inpatient Days	= P.4.2, C.1, L.330
100	Purchasing and Stores	$1000 of Gross Non-Capitalized Purchases	≤ P.18, C.5, L.375÷1000
105	Grounds	Number of Square Feet of Ground Space	
110	Security	Number of *Hospital* FTE Employees	= (∑ P.21 + 22, C.24)÷2080
115	Parking	Number of Square Feet of Parking Area	
120	Housekeeping	Number of Square Feet Serviced	~~=~~ ≤ > P.19, C.7, L.920
125	Plant Operations	Number of Gross Square Feet	> P.19, C.2, L.920
130	Plant Maintenance	Number of Gross Square Feet	> P.19, C.2, L.920
135	Communications	Average Number of Hospital Employees	>(∑ P.21+22, C.24)÷2080
140	Data Processing	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
	FISCAL SERVICES		
155	General Accounting	Average Number of Hospital Employees	> (∑ P.21 + 22, C.24)÷2080
160	Patient Accounting	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000

REPORTING REQUIREMENTS

165	Credit and Collection	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
170	Admitting	Number of Admissions	≈ P.4.1, C.12, L.150
175	Outpatient Registration	Number of Registrations	≤ P.4.2, C.1, L.560

ADMINISTRATIVE SERVICES

205	Hospital Administration	Number of *Hospital* FTE Employees	=(∑ P.21 + 22, C.24)÷2080
210	Governing Board Expense	$1,000 of Total Operating Revenue	=(P.8,C.1,L.30+L.135)÷1000
215	Public Relations	$1,000 of Total Operating Revenue	=(P.8,C.1,L.30+L.135)÷1000
220	Management Engineering	Number of *Hospital* FTE Employees	=(∑ P.21 + 22, C.24)÷2080
225	Personnel	Average Number of Hospital Employees	>(∑ P.21 + 22, C.24)÷2080
230	Employee Health Svcs.	Number of *Hospital* FTE Employees	=(∑ P.21 + 22, C.24)÷2080
235	Auxiliary Groups	Number of Volunteer Hours	
240	Chaplaincy Services	Number of Patient (Census) Days	= P.4.1,C.4+C.5,L.150
245	Medical Library	Number of Physicians on Active Staff	=P.1, C.1+2+3+4+5+6, L.320
250	Medical Records	Number of Adjusted Patient Days	=(P.12, C.25, L.415÷P.12, C.21, L.415) X(P.4.1, C.4+5, L.150)
255	Medical Staff Administration	Number of Physicians on Active Staff	= P.1, C1+2+3+4+5+6,L.320
260	Nursing Administration	Average Number of Nursing Service Personnel	>(∑ P.21,C.6+8+10 + P.21.1, C.2)÷2080
270	Inservice Education - Nursing	Number of Hours of Nursing Inservice Education	
275	Utilization Management	Number of Admissions	≈ P.4.1,C.12, L.150
280	Community Health Education	Number of Participants	

REPORTING REQUIREMENTS

UNASSIGNED COSTS

305	Depreciation and Amortization	Number of Gross Square Feet Owned	
310	Leases and Rentals	Number of Gross Square Feet Leased	
315	Insurance Hospital and Professional Malpractice	$1,000 of Gross Patient Revenue	= P.8, C.1, L30÷1000
320	Insurance - Other	Number of Gross Square Feet	> P.19, C.2, L.920
325	Licenses and Taxes (other than on income)	Number of Gross Square Feet	> P.19, C.2, L.920
330	Interest - Working Capital	$1,000 of Gross Patient Revenue	= P.8, C.1, L.30÷1000
345	Interest - Other	Number of Gross Square Feet	> P.19, C.2, L.920
350	Employee Benefits (Non-Payroll)	Number of *Hospital* FTE Employees	=(∑ P.21 + 22, C.24)÷2080

$1,000 of Gross Patient Revenue = P.8, C.1, L.30÷1000. Appears on lines 5, 140, 160, 165, 315, and 330.

Gross Square Feet >P.19, C.2, L.920. Appears on lines 125, 130, 320, 325 and 345.

Number of *Hospital* FTEs = sum of P.21 + 22, C.24÷2080. Appears on lines 110, 205, 220, 230, and 350.

17. The completion of column 14 is optional. The hospital may elect to have the Office do these calculations. If this column is affected by errors in previous portions of the report, the corrections to column 14 will be made automatically. If the hospital elects the Office to generate column 14, skip to step 19.

18. Calculate the adjusted direct expense per unit of service to the second decimal by dividing column 12 by column 13 and enter the result in column 14.

19. ~~Total~~ *For report periods ending on or before June 29, 2000, total* page 17, lines 5 through 145 on line 150, lines 160 through 220 on line 225, lines 230 through 400 on line 405, and lines 150, 225, 405, and 410 on line 415.

REPORTING REQUIREMENTS

For report periods ending on or after June 30, 2000, total page 17, lines 5 through 145 on line 150, lines 160 through 220 on line 225, lines 230 through 400 on line 405, and lines 150, 225, and 405 on line 415.

20. Total page 18, line 5 on line 10; lines 15 through 45 on line 50; lines 55 through 145 on line 150; lines 155 through 195 on line 200; lines 205 through 295 on line 300, and lines 305 through 355 on line 360.

21. Enter on page 18, line 365, the sum of line 415, page 17, and lines 10, 50, 150, 200, 300 and 360, page 18.

22. Enter non-operating expenses on line 370. The total in column 11, line 370 must agree with the amount on page 8.1, column 1, line 425.

23. Total lines 365 and 370, page 18, on line 375.

24. The total direct operating costs on page 18, column 10, line 365 plus the Physicians' Professional Component on page 16, column 9, line 305 must equal the total operating expense on page 8, column 1, line 200.

25. The total cost recoveries on page 18, column 11, line 375 must agree with the amount on page 14, line 120.

Pages 21 AND 22 DETAIL OF DIRECT PAYROLL COSTS 7020.6

These two pages are used to report the productive hours and average hourly rate by employee classification by cost center. In addition, full-time equivalent employees are determined based on productive hours. The hours and average hourly rates reported on these pages must reflect reclassifications made to the cost center data reported on pages 17 and 18.

1. Enter the productive hours for each natural classification of salaries and wages by cost center in the appropriate columns 2, 4, 6, 8, 10, 12, 14, 16, 18, and 20. Productive hours equal total paid hours less hours not on the job. Hours not on the job include vacation time, sick time, holidays, and other paid time-off. Overtime pay and premium pay for "on-call" or "stand by" time must be included in salaries and wages.

   However, only actual hours worked must be included in productive hours. "On-call" time is not to be included in productive or non-productive hours. Calculate full-time salaried physicians as 40 hours per week each unless they have a definite schedule with identifiable hours, and actual hours are available. Report whole hours only. Labor hours related to capitalized labor costs should be excluded.

REPORTING REQUIREMENTS

7. Enter the total of lines 5 through 280, column 1, page 20, on line 285.

8. Enter the total of lines 350 through 435, column 1, page 20, on line 440.

9. Enter the total of lines 505 through 645, column 1, page 20, on line 650.

10. Enter the total of lines 660 through 720, column 1, page 20, on line 725.

11. Enter the total of lines 730 through 900 column 1, page 20, on line 905.

12. ~~Enter~~ *For report periods ending on or before June 29, 2000, enter* on line 920, column 1, page 20, the total of lines 285, 440, 445, 650, 725, 905, 910, and 915, column 1. *For report periods ending on or after June 30, 2000, enter on line 920, column 1, page 20, the total of lines 285, 440, 445, 650, 725, 905, and 915, column 1.* ~~This~~ *In both cases, this* total should equal the total of page 8, column 1, line 200, minus page 14, column 1, line 280 (Other Operating Revenue), minus page 16, column 9, line 305 (Physician and Intern/Resident Care of Hospital Patients), and plus page 18, column 12, line 370.

13. Total page 20, lines 350 through 435, columns 2, 4 through 15, and 17 through 21, and enter the results on line 440, column as appropriate.

14. Enter square feet occupied by each cost center in column 2, page 19. Square feet occupied excludes common and unused areas and is computed as specified in Section 5032. Foot the column and enter the total on line 920.

15. The first allocation follows and it typifies the process of allocating the non-revenue producing centers:

    Total lines 5 through 25, column 1, page 20, and enter the sum on line 25, column 2, page 20, as a bracketed figure. Transfer the amount on page 20, line 25, column 2, to page 19, column 2, line 925 as an unbracketed figure. Transfer the total cost recoveries from lines 440 and 445, column 2, page 20, to page 19, column 2, line 930. Subtract on page 19, column 2, line 930 from line 925, and enter net cost on line 935.

    Calculate the unit multiplier to at least seven decimals by dividing line 935 by line 920. Enter the unit multiplier to three decimals on line 940, column 2. Multiply the seven decimal place unit multiplier times each cost center's square feet occupied which has been entered in column 2, lines 35 through 915 on page 19. Enter the results on corresponding lines on page 20, column 2. Total page 20, column 2, lines 505 through 645 on line 650, total lines 660 through 720 on line 725, and total lines 730 through 900 on line 905. ~~Total~~ *For report periods ending on or before June 29, 2000, total* page 20,

REPORTING REQUIREMENTS

column 2, lines 25 through 280, 440, 635, 905 440, 445, 650, 725, 905, 910 and 915 and enter the result on line 920. *For report periods ending on or after June 30, 2000, total page 20, column 2, lines 25 through 280, 440, 635, 905 440, 445, 650, 725, 905, and 915 and enter the result on line 920.* The total must be zero because the first figure of the column is bracketed and all other figures in the column are unbracketed.

NOTE: The total on line 920 in columns 2, 4 through 15, and 17 through 22 must be zero. It may be necessary due to rounding to adjust the allocated amounts in order that the total on line 920 for these columns will equal zero. When adjusting the allocation, do not adjust only one item, as this will distort the allocation. Instead, adjust those items on which the adjustment will have the least affect percentage-wise.

16. Subtotal columns 1 and 2, page 20, to column 3 to identify the total accumulated costs in the surviving cost centers at that point in the allocation process. ~~Column~~ *For report periods ending on or before June 29, 2000, column* 3 amounts are calculated by adding the adjusted direct costs from column 1 to the allocated costs in column 2 for lines 30 through 280, lines 350 through 435, 445, 505 through 645, 660 through 720, 730 through 900, 910, and 915. *For report periods ending on or after June 30, 2000, column 3 amounts are calculated by adding the adjusted direct costs from column 1 to the allocated costs in column 2 for lines 30 through 280, lines 350 through 435, 445, 505 through 645, 660 through 720, 730 through 900, and 915.*

17. Subtotal column 3, page 20, lines 30 through 280 on line 285, lines 350 through 435 on line 440 lines 505 through 645 on line 650, lines 660 through 720 on line 725, and lines 730 through 900 on line 905. ~~Determine~~ *For report periods ending on or before June 29, 2000, determine* the final total by adding lines 285, 440, 445, 650, 725, 905, 910, and 915. *For report periods ending on or after June 30, 2000, determine the final total by adding lines 285, 440, 445, 650, 725, 905, and 915.* ~~Enter~~ *In both cases, enter* the result on line 920 for column 3.

18. Transfer accumulated cost figures from column 3, page 20, lines 85 through 280, and lines 505 through 645 and 660 through 720, and lines 730 through 900 to the appropriate lines, page 19, column 4. Line 915 page 20, column 3, would be transferred to page 19, column 4, line 915 only <u>if</u> the non-operating cost centers should absorb the overhead being allocated in column 4.

19. Enter in column 5, page 19, the hospital full-time equivalent data computed on pages 21 and 22, column 25. FTE's must be recorded to two decimal places. (Enter zeros if necessary.)

20. Enter in column 6, page 19, supply costs from pages 17 and 18, column 5. The amounts on pages 17 and 18, column 5, represent <u>direct</u> costs for supplies.

21. Enter in column 7, page 19, square feet serviced by the Housekeeping cost center during the reporting period. These figures should be equal to or less than the figures recorded in column 2. Do not enter percentages.

22. Transfer square feet occupied from page 19, column 2 to page 19, column 8 for all remaining (open) cost centers.

REPORTING REQUIREMENTS

38. Continue the allocation process for columns 17 through 21. Since the allocated costs have been subtotaled in column 16, the amounts to be allocated for columns 17 through 21 are summarized from, and including, column 16.

39. On line 445, column 22, page 20, is the amount of transfers from restricted funds for operating costs for revenue-producing centers. Column 22 is used to offset such transferred funds against the related costs. Enter such transfers in the appropriate cost centers in column 22, lines 505 through 900, on the basis of the transfers to the unrestricted fund, (i.e., as restricted).

40. Total columns 16 through 22, lines 505 through 915, page 20, and enter the results in column 23.

41. Complete footings as appropriate. The totals on page 20, line 920, columns 1, 3, 16, and 23 must be equal.

Page 8.1 STATEMENT OF INCOME - UNRESTRICTED FUND (NON-OPERATING REVENUE AND EXPENSE) 7020.11

This page is used to report the non-operating revenue and expense of the hospital for ~~the reporting period~~ *report periods ending on or before June 29, 2000*. The total net non-operating revenue and expense from this page is reported on page 8 of the report. The total non-operating expense from this page is reported on page 18 of the report. *For report periods ending on or after June 30, 2000, this page has been combined with report page 8 (See Instruction No. 2 in Manual Section 7020.12)*

~~Effective with reporting periods ending on or after December 31, 1993, the~~ *The* prior year column (column 2) is optional if all data items are the same as reported on the previous year's report (column 1). If there has been a restatement or adjustment since the previous report was filed, the prior year column must be completed.

1. Enter gains on sale of hospital property (Account 9010) on line 260.

2. Enter maintenance of restricted funds revenue (Account 9030) on line 265.

3. Enter unrestricted contributions (Account 9040) on line 270.

4. Enter donated services (Account 9050) on line 275.

5. Enter income, gains and losses from unrestricted investments (Account 9060) on line 280. Include all unrestricted non-patient interest income.

6. Enter unrestricted income from endowment funds (Account 9070) on line 285.

7. Enter unrestricted income from other restricted funds (Account 9080) on line 290.

REPORTING REQUIREMENTS

8. Enter term endowment funds becoming unrestricted (Account 9090) on line 295.

9. Enter transfers from restricted funds for non-operating expenses (Account 9100) on line 300.

10. District hospitals enter assessment revenue (Account 9150), county allocation of tax revenue (Account 9160), special district augmentation revenue (Account 9170), debt service tax revenue (Account 9180), and State Homeowner's Property Tax Relief (Account 9190) on lines 305, 310, 315, 320 and 325, respectively.

11. State and district hospitals only enter on line 330 the amount appropriated from the State General Fund (Account 9200) or other State sources for operating deficits or other operating needs. The amount reported should not exceed the actual amount of the appropriation(s) expended and/or encumbered.

12. County hospitals enter on lines 335, 340 and 345, the amount appropriated from the County General Fund or other sources for operating deficits or other operating needs. Enter on line 335 the amount of Realignment funds unrelated to direct patient care (Account 9210) provided to the hospital. See Section 1280 of the Manual for more information on Realignment Funds. Enter on line 340 the amounts of County General Funds provided (Account 9220). Enter on line 345 the amount of Other Funds (Account 9230) provided by the County. The amounts reported should not exceed the actual amount of the appropriations(s) expended and/or encumbered. If a County hospital repays the County any portion of the County appropriations(s), the repayment must be abated against current year appropriations.

13. Enter physicians' offices and other rentals revenue (Account 9250) on line 350.

14. Enter on line 355 medical office building revenue (Account 9260).

15. Enter on line 360 child care service revenue (non-employees) (Account 9270).

16. Enter on line 365 family housing revenue (Account 9280).

17. Enter retail operations revenue (Account 9290) on line 370.

18. Enter other non-operating revenue (Account 9400) on line 375.

19. Total lines 260 through 375 and enter the resulting total non-operating revenue on line 380.

20. Enter losses on sale of hospital property (Account 9020) on line 385.

REPORTING REQUIREMENTS

21. Enter maintenance of restricted funds expenses (Account 9030) on line 390.

22. Enter physicians' offices and other rentals expenses (Account 9510) on line 395.

23. Enter on line 400 medical office building expense (Account 9520).

24. Enter on line 405 child care service expense (Non-Employees) (Account 9530).

25. Enter on line 410 family housing expense (Account 9540).

26. Enter retail operations expenses (Account 9550) on line 415.

27. Enter other non-operating expenses (Account 9800) on line 420.

28. Total lines 385 through 420 and enter the resulting total non-operating expenses on line 425. This amount must agree with page 18, column 10, line 370.

29. Subtract line 425 from line 380 and enter net non-operating revenue and expenses on line 430. Transfer this total to page 8, line 210.

30. District hospitals enter on line 435 the amount of interest expense on long-term debt included on page 8, line 180.

Page 8 STATEMENT OF INCOME - UNRESTRICTED FUND 7020.12

This page is used to report the revenue and expenses of the hospital for the reporting period. Although this report could be developed from the general ledger accounts, for the most part this report is completed by using data contained in previously completed report pages.

Enter current year data in column 1. Enter prior year data in column 2 from the previous year's report.

~~For reporting periods ending on or after December 31, 1993, the~~ *The* prior year column (column 2) is optional if all data items are the same as reported on the previous year's report (column 1). If there has been a restatement or adjustment since the previous report was filed, the prior year column must be completed. If column 2 is completed, ~~attach~~ *submit* a brief explanatory statement as to what these differences are and the reasons for them *as an attachment to the certification required by Manual Section 7020.24*.

For report periods ending on or before June 29, 2000, complete report page 8 following the instructions specified in Instruction No. 1. For report periods ending on or after June 30, 2000, complete report page 12 following the instructions specified in Instruction No. 2.

REPORTING REQUIREMENTS

Instruction No. 1 (Report Periods ending on or before June 29, 2000)

1. Enter in column 1, line 5, the total daily hospital services gross revenue from page 12, column 25, line 150.

2. Enter on line 10, the total ambulatory services gross revenue from page 12, column 25, line 225.

3. Enter on line 15, the total ancillary services gross revenue from page 12, column 25, line 405.

4. Enter on line 20 the total purchased inpatient services gross revenue from page 12, column 25, line 410.

5. Total lines 5, 10, 15 and 20, on line 30. This total gross patient revenue must agree with the gross patient revenue on page 12, column 25 line 415.

6. Enter provisions for bad debts (Account 5800) on line 35. This is the amount of gross revenue which will not be paid by those unwilling to pay. Do not enter on this line amounts related to medically indigent patients (i.e., patients with an inability to pay). Such amounts must be recorded as charity discounts.

7. Enter Medicare contractual adjustments (Account 5810) on line 40.

8. Enter Medi-Cal contractual adjustments (Account 5820) on line 45 and Medi-Cal disproportionate share payments (Account 5821) on line 46. Be sure that disproportionate share payments reported on line 46 are not also included on line 45.

9. Enter County Indigent Programs contractual adjustments (Account 5830) on line 50.

10. Enter HMO/PPO and Other Contracts contractual adjustments (Account 5840) on line 55. Report capitation premium revenue separately on line 56.

11. Enter Capitation Premium Revenue (Account 5841) on line 56.

12. Enter other contractual adjustments (Account 5850) on line 60.

13. Enter Hill-Burton Charity Discounts (Account 5860) on line 65 and Other Charity Discounts (Account 5870) on line 70. See Section 1400 for the definition of Charity Care.

14. Enter restricted donations and subsidies for indigent care (Account 5880) on line 75.

REPORTING REQUIREMENTS

15. Only University of California teaching hospitals are to complete lines 80 and 85. Enter Support for Clinical Teaching (Account 5910) and Teaching Allowances (Account 5890) on lines 80 and 85, respectively.

16. Enter policy discounts (account 5970) administrative adjustments (Account 5980), and other deductions from revenue (Account 5990) on lines 90, 95, and 100, respectively.

17. Sum deductions from revenue amounts, lines 35 through 100, and enter the total on line 105. This total must agree with page 12, column 25, line 455.

18. Subtract deductions from revenue on line 105 from gross patient revenue on line 30 and enter the resulting net patient revenue on line 110. The figure on line 110 must equal page 12, column 25, line 460.

19. Enter on line 135 total other operating revenue from page 14, column 1, line 280.

20. Add net patient revenue and total other operating revenue on lines 110 and 135, and enter the resulting total operating revenue on line 140.

21. Enter on line 145 total salaries and wages expense from page 18, column 1, line 365 and page 15, column 1, line 305.

22. Enter on line 150 total employee benefits expense from page 18, column 2, line 365, and page 16, column 2, line 305.

23. Enter on line 155 the total professional fees expense from page 18, column 4, line 365 and page 16, column 3, line 305.

24. Enter on line 160 total supplies expense from page 18, column 5, line 365.

25. Enter on line 165 total purchased services from page 18, column 6, line 365.

26. Enter on line 170 total depreciation expense from page 18, column 7, line 365.

27. Enter on line 175 total leases and rentals expense from page 18, column 8, line 365.

28. Enter on line 180 total Interest expense from page 18, column 9, line 330 plus line 345.

29. Enter on line 185 all other direct expenses from page 18, column 9, line 365 minus lines 330 and 345.

30. Total lines 145 through 185 and enter the result on line 200. Line 200 must agree with page 18, column 10, line 365 plus page 16, column 9, line 305.

REPORTING REQUIREMENTS

31. Subtract total operating expense line 200 from total operating revenue line 140 and enter net from operations on line 205.

32. Enter on line 210 the net non-operating revenue from page 8.1, line 430.

33. Total lines 205 and 210 and enter the resulting net income before taxes and extraordinary items on line 215.

34. Enter current provision for income taxes (Accounts 9901 and 9903 on line 220).

35. Enter deferred provision for income taxes (Accounts 9902 and 9904 on line 225).

36. Subtract lines 220 and 225 from line 215 and enter the resulting net income before extraordinary items on line 230).

37. Enter extraordinary items (Account 9920 on lines 235 and 240 Provide a brief description (up to 50 characters) of each item. Enter extraordinary income amounts as negative (bracketed) figures.

38. Subtract lines 235 and 240 from line 230 and enter the resulting net income (loss) on line 245.

Instruction No. 2 (Report Periods ending on or after June 30, 2000)

1. *Enter in column 1, line 5, the total daily hospital services gross revenue from page 12, column 45, line 150.*

2. *Enter on line 10, the total ambulatory services gross revenue from page 12, column 45, line 225.*

3. *Enter on line 15, the total ancillary services gross revenue from page 12, column 45, line 405.*

4. *Total lines 5, 10, and 15 on line 30. This total gross patient revenue must agree with the gross patient revenue on page 12, column 45 line 415.*

5. *Go to line 300. Enter provisions for bad debts (Account 5800) on line 300. This is the amount of gross revenue which will not be paid by those unwilling to pay. Do not enter on this line amounts related to medically indigent patients (i.e., patients with an inability to pay). Such amounts must be recorded as charity discounts.*

6. *Enter Medicare - Traditional contractual adjustments (Account 5811) on line 305.*

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7. Enter Medicare - Managed Care contractual adjustments (Account 5812) on line 310.

8. Enter Medi-Cal -Traditional contractual adjustments (Account 5821) on line 315 and Medi-Cal disproportionate share payments (Account 5830) on line 325. Be sure that disproportionate share payments reported on line 325 are not also included on line 315.

9. Enter Medi-Cal - Managed Care contractual adjustments (Account 5822) on line 320.

10. Enter County Indigent Programs -Traditional contractual adjustments (Account 5841) on line 330.

11. Enter County Indigent Programs - Managed Care contractual adjustments (Account 5842) on line 335.

12. Enter Other Third Parties - Traditional contractual adjustments (Account 5851) on line 340.

13. Enter Other Third Parties - Managed Care contractual adjustments (Account 5852) on line 345.

14. Enter Hill-Burton Charity Discounts (Account 5860) on line 350 and Other Charity Discounts (Account 5870) on line 355. See Section 1400 for the definition of Charity Care.

15. Enter restricted donations and subsidies for indigent care (Account 5880) on line 360.

16. Only University of California teaching hospitals are to complete lines 365 and 370. Enter Support for Clinical Teaching (Account 5910) and Teaching Allowances (Account 5890) on lines 365 and 370, respectively.

17. Enter policy discounts (account 5920) administrative adjustments (Account 5930), and other deductions from revenue (Account 5940) on lines 375, 380, and 385, respectively.

18. Sum deductions from revenue amounts, lines 300 through 385, and enter the total on line 395. Enter the same total on line 105. This total must agree with page 12, column 45, line 455.

19. Go to line 430. Enter on line 430 the Medicare capitation premium revenue (Account 5960). The figure on line 430 must equal page 12, column 1, line 457.

20. Enter on line 435 the Medi-Cal capitation premium revenue (Account 5970). The figure on line 435 must equal page 12, column 9, line 457.

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21. Enter on line 440 the County Indigent Programs capitation premium revenue (Account 5980). The figure on line 440 must equal page 12, column 17, line 457.

22. Enter on line 445 the Other Third Parties capitation premium revenue (Account 5990). The figure on line 445 must equal page 12, column 25, line 457.

23. Total lines 430 through 445 and enter the result on line 450. Enter the same total on line 107. This total must agree with page 12, column 45, line 457.

24. Go to line 110. Subtract deductions from revenue on line 105 from gross patient revenue on line 30, then add capitation premium revenue on line 107 and enter the resulting net patient revenue on line 110. The figure on line 110 must equal page 12, column 45, line 460.

25. Enter on line 135 total other operating revenue from page 14, column 1, line 280.

26. Add net patient revenue and total other operating revenue on lines 110 and 135, and enter the resulting total operating revenue on line 140.

27. Enter on line 146 the sum of Daily Hospital Services total direct expenses from page 17, column 10, line 150, plus the professional component amount from page 15, column 9, line150.

28. Enter on line 151 the sum of Ambulatory Services total direct expenses from page 17, column 10, line 225, plus the professional component amount from page 15, column 9, line 225.

29. Enter on line 156 the sum of Ancillary Services total direct expenses from page 17, column 10, line 405, plus the professional component amount from page 15, column 9, line 405.

30. Enter on line 161 the Research total direct expenses from page 18, column 10, line 10.

31. Enter on line 166 the Education total direct expenses from page 18, column 10, line 50.

32. Enter on line 171 the General Services total direct expenses from page 18, column 10, line 150.

33. Enter on line 176 the Fiscal Services total direct expenses from page 18, column 10, line 200.

34. Enter on line 181 the Administration total direct expenses from page 18, column 10, line 300.

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35. Enter on line 186 the Unassigned Costs total direct expenses from page 18, column 10, line 360.

36. Enter on line 190 the Purchased Inpatient Services total direct expenses from page 17, column 10, line 410.

37. Enter on line 195 the Purchased Outpatient Services total direct expenses from page 17, column 10, line 411.

38. Total lines 146 through 195 and enter the result on line 200. Line 200 must agree with page 18, column 10, line 365 plus page 16, column 9, line 305.

39. Subtract total operating expense line 200 from total operating revenue line 140 and enter net from operations on line 205.

40. Go to line 500. Enter gains on sale of hospital property (Account 9010) on line 500.

41. Enter maintenance of restricted funds revenue (Account 9030) on line 505.

42. Enter unrestricted contributions (Account 9040) on line 510.

43. Enter donated services (Account 9050) on line 515.

44. Enter income, gains and losses from unrestricted investments (Account 9060) on line 520. Include all unrestricted non-patient interest income.

45. Enter unrestricted income from endowment funds (Account 9070) on line 525.

46. Enter unrestricted income from other restricted funds (Account 9080) on line 530.

47. Enter term endowment funds becoming unrestricted (Account 9090) on line 535.

48. Enter transfers from restricted funds for non-operating expenses (Account 9100) on line 540.

49. District hospitals enter assessment revenue (Account 9150), county allocation of tax revenue (Account 9160), special district augmentation revenue (Account 9170), debt service tax revenue (Account 9180), and State Homeowner's Property Tax Relief (Account 9190) on lines 545, 550, 555, 560, and 565, respectively.

50. State and district hospitals only enter on line 570 the amount appropriated from the State General Fund (Account 9200) or other State sources for operating deficits or other operating needs. The

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amount reported should not exceed the actual amount of the appropriation(s) expended and/or encumbered.

51. *County hospitals enter on lines 575, 580, and 585, the amount appropriated from the County General Fund or other sources for operating deficits or other operating needs. Enter on line 575 the amount of Realignment funds unrelated to direct patient care (Account 9210) provided to the hospital. See Section 1280 of the Manual for more information on Realignment Funds. Enter on line 580 the amounts of County General Funds provided (Account 9220). Enter on line 585 the amount of Other Funds (Account 9230) provided by the County. The amounts reported should not exceed the actual amount of the appropriations(s) expended and/or encumbered. If a County hospital repays the County any portion of the County appropriations(s), the repayment must be abated against current year appropriations.*

52. *Enter physicians' offices and other rentals revenue (Account 9250) on line 590.*

53. *Enter on line 595 medical office building revenue (Account 9260).*

54. *Enter on line 600 child care service revenue (non-employees) (Account 9270).*

55. *Enter on line 605 family housing revenue (Account 9280).*

56. *Enter retail operations revenue (Account 9290) on line 610.*

57. *Enter other non-operating revenue (Account 9400) on line 615.*

58. *Total lines 500 through 615 and enter the resulting total non-operating revenue on line 625.*

59. *Enter losses on sale of hospital property (Account 9020) on line 640.*

60. *Enter maintenance of restricted funds expenses (Account 9030) on line 645.*

61. *Enter physicians' offices and other rentals expenses (Account 9510) on line 650.*

62. *Enter on line 655 medical office building expense (Account 9520).*

63. *Enter on line 660 child care service expense (Non-Employees) (Account 9530).*

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64. Enter on line 665 family housing expense (Account 9540).

65. Enter retail operations expenses (Account 9550) on line 670.

66. Enter other non-operating expenses (Account 9800) on line 675.

67. Total lines 640 through 675 and enter the resulting total non-operating expenses on line 685. This amount must agree with page 18, column 10, line 370.

68. Subtract line 685 from line 625 and enter net non-operating revenue and expenses on line 700. Transfer this total to line 210.

69. District hospitals enter on line 705 the amount of interest expense on long-term debt included on page 8, line 186.

70. Go to line 215. Total lines 205 and 210 and enter the resulting net income before taxes and extraordinary items on line 215.

71. Enter current provision for income taxes (Accounts 9901 and 9903) on line 220.

72. Enter deferred provision for income taxes (Accounts 9902 and 9904) on line 225.

73. Subtract lines 220 and 225 from line 215 and enter the resulting net income before extraordinary items on line 230.

74. Enter extraordinary items (Account 9920 on lines 235 and 240 Provide a brief description (up to 50 characters) of each item. Enter extraordinary income amounts as negative (bracketed) figures.

75. Subtract lines 235 and 240 from line 230 and enter the resulting net income (loss) on line 245.

Page 1 HOSPITAL DESCRIPTION 7020.13

This page reports some descriptive information about the hospital, such as: Type of Control, Type of Care, and a profile of the active medical staff.

1. Enter on line 5, column 1, the number of licensed beds at the end of the reporting period. The number of licensed beds must agree with page 4.1, column 1, line 150. Total licensed beds must include residential care beds where medical care is given; even though these beds are not licensed by the same agency licensing acute care beds. *Do not include licensed beds placed in suspense.*

2. Enter on line 10 the daily average complement of beds (excluding bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds in nursing units converted to uses other than inpatient overnight accommodations

REPORTING REQUIREMENTS

4. Complete E. Trusteed funds are those funds held by a third party that are not reflected on the balance sheet. Examples of trusteed funds include pension plan assets and donated assets held in trust. Board designated assets are not trusteed funds.

5. Item F lists several common hospital cost centers and six general types of financial arrangements which exist between hospital and physicians. Indicate the financial arrangement for each listed service provided at the facility. (See Section 1191 for definitions of financial arrangements.) Comments on lines 33 through 36 are limited to 60 characters each.

6. All hospitals must complete item G for all governing board members. Proprietary hospitals must also complete item G for all owners having a five percent or more interest in the hospital. Enter each person's principal occupation in column 2. Do not report "board member" titles as occupations unless it is their principle occupation. Check column 3 to indicate ownership and column 5 to indicate board membership. Indicate in column 4 the percent of ownership for all owners having a five percent or more interest. Column 6 is to be completed for all owners and board members which received compensation for services rendered personally to or on behalf of the hospitals, regardless of the source. If the owner is not compensated please enter "none".

7. *For report periods ending on or after June 30, 2000, skip item H and go to item I.* For *report periods ending on or before June 29, 2000, complete* item H ~~report~~ *with* the patient (census) days and outpatient visits in aggregate for Health Maintenance Organizations as defined by statute to be:

   Any person who undertakes to arrange for the provision of health care services to subscribers enrollees, or to pay for or reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees. This should include those health service plans which are full service plans, or not-for-profit hospital plans.

   All other patient (census) days and outpatient visits for patients treated under contracted plans not included in the above definition will be reported as Other Managed Care. Include Medicare and Medi-Cal managed care in the appropriate category.

8. Item I must be completed only by hospitals which are closely held corporations (10 or fewer owners). Enter in column 1 the name of each physician which is an owner of the hospital, or an owner of the corporation which owns the hospital and has a business relationship with the hospital. For each physician named in column 1, enter in column 2 the percent of the stock owned and describe in column 3 all contract, lease and other business relationships between the hospital and the physician. More than one line may be used for each physician, if needed. (Limit the information entered on each line in column 3 to 60 characters.)

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9. Answer Line 80 (Item J) "yes" if the hospital is operated by a management firm that is not the parent company. If the facility is operated by a management firm complete lines 81 to 102. For item L (lines 88 to 97), limit the services listed on each line to 55 characters. For lines 99 to 102, limit the explanation to 60 characters per line.

Page 4.1 PATIENT CENSUS STATISTICS 7020.16*a*

This page is *required for report periods ending on or before June 29, 2000 and is* used to report various patient related statistical information of the hospital, including: licensed beds, available beds, staffed beds, adult and pediatric patient (census) days, Medicare, Medi-Cal, County Indigent Programs, Third-Parties, and Other Payors patient (census) days, number of service discharges, number of hospital discharges, and number of Medicare, Medi-Cal, County Indigent Programs, Third-Parties, and Other Payors discharges. *For reports ending on or after June 30, 2000, see Manual section 7020.16b.* Third-Parties include all payors liable for a patient's bill other than Title XVIII, Title XIX, County Indigent Programs, Charity, Self-Pay or Other Payors. See Manual sections 7020.2 and 2430.

1. Insert on line 155, column 1 the number of bassinets at the end of the reporting period. On the remaining lines in column 1, enter the number of licensed beds, at the end of the reporting period by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. *Do not include license beds placed in suspense.* The total licensed beds in column 1, on line 150, must agree with page 1, column 1, line 5.

2. Insert on line 155, column 2 the reporting period monthly average number of bassinets. Enter on the remaining lines of column 2 the monthly average number of available beds by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total available beds in column 2, on line 150, must agree with page 1, column 1, line 10.

3. Insert the reporting period monthly average number of staffed bassinets (set up and staffed for use) on line 155, column 3. Enter the monthly average of staffed (set up and staffed) beds by discrete Daily Hospital Services cost center on lines 5 through 145 as dictated by organizational unit or by beds dedicated for a particular clinic use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total staffed beds in column 3, line 150, must agree with page 1, column 1, line 15.

4. Insert adult patient (census) days in column 4 and pediatric patient (census) days in column 5 by the functional Daily Hospital Services cost center related to the level and type of care the patient is receiving

REPORTING REQUIREMENTS

as of the point in time of the hospital daily census tabulation. Enter newborn days on line 155, column 5. Recognizing that newborns are neither formally admitted nor discharged, count the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient or newborn (census) day. If a patient is moved from one functional cost center to another, actual patient (census) days spent in each would be reported. If pediatric patients are cared for in a combined adult/pediatric medical/surgical acute unit, the pediatric patient (census) days must be reported in the pediatric acute cost center. GYN patient (census) days are not to be included in the Obstetrics Acute cost center even though the patient may have been housed in that unit. Such patient (census) days must be included in the Medical/ Surgical Acute cost center. Do not enter patient (census) days in the shaded areas.

NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

5. Enter the number of patient (census) days in column 6, by functional Daily Hospital Services cost center, for which Medicare was the principal third-party payor during the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined as in step 4 above.

6. Enter the number of patient (census) days in column 7, by functional Daily Hospital Services cost center, for which Medi-Cal was the principal third-party payor during the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined as in Step 4 above.

7. Enter in column 8 the number of County Indigent Programs patient (census) days, by functional Daily Hospital Services cost center, for those patients considered to be covered under County Indigent Programs during all or part of the patient's period of hospitalization. Enter newborn days on line 155. Patient (census) days are defined in Step 4 above.

   A patient under County Indigent Programs is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

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8. Enter in column 9 the number of Third-Parties patient (census) days for which a payor other than Title XVIII (Medicare) or Title XIX (Medi-Cal) County Indigent Programs or Other Payors was the principal payor during the patient's hospitalization. Enter newborn days on line 155. Patient (census) days are defined in step 4 above.

   A Third-Parties patient is a patient covered by a private indemnity insurance carrier, a Health Maintenance Organization, a Preferred Provider Organization, Crippled Children's' Services, Tricare (CHAMPUS), or California Health and Disability Prevention.

9. Enter in column 10 the number of Other Payors patient (census) days for which a payor other than Title XVIII (Medicare) or Title XIX (Medi-Cal) or County Indigent Program or Third-Parties was the principal payor during the hospitalization. Enter newborn days on line 155. Patient (census) days are defined in step 4 above.

NOTE: Line by line, the sum of patient (census) days in columns 6 through 10 must be equal to the sum of columns 4 and 5.

10. Enter in column 11 the number of service discharges by functional Daily Hospital Services cost center for those patients discharged (transferred) <u>from</u> one cost center to another cost center within the hospital. Service discharges are to be counted by the cost center transferring the patient and <u>not</u> by the cost center receiving the patient. Hospital discharges as defined in Section 4120 of the Manual are <u>not</u> included here.

    When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such transfers are <u>not</u> to be counted as service discharges. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients. Therefore, no service discharges should ever be reported for the nursery cost center.

11. Enter in column 12 the total number of discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. See Section 4120 of the Manual for the definition of a discharge. Report newborn discharges on line 155.

12. Enter in column 13 the total number of Medicare discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged . Report newborn discharges on line 155.

13. Enter in column 14 the total number of Medi-Cal discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged . Report newborn discharges on line 155.

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14. Enter in column 15 the total number of County Indigent Programs patient discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. Report newborn discharges on line 155.

    A patient under County Indigent Programs is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds, (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

15. Enter in column 16 the total number of Third-Parties discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. Report newborn discharges on line 155.

16. Enter in column 17 the total number of Other Payors patient discharges (including deaths) in the functional Daily Hospital Service cost center from which the patients were discharged. Report newborn discharges on line 155.

    Note: The sum of patient discharges for each cost center in columns 13 through 17 must equal the total discharges in Column 12.

17. Total lines 5 through 145, for all the columns, and enter the results on line 150.

18. Enter on line 156, column 1, the average length of stay (ALOS) for Medi-Cal patients (excluding newborn). Compute Medi-Cal ALOS by dividing Medi-Cal patient (census) days from column 7, line 150 by Medi-Cal discharges from column 14, line 150. Round to two decimal places (enter zeros if necessary).

19. Enter on line 157, column 1 the average length of stay (ALOS) for County Indigent Programs patients (excluding newborn). Compute ALOS by dividing indigent patient (census) days from column 8, line 150, by County Indigent Programs discharges from column 15, line 150. Round to two decimal places (enter zeros if necessary).

20. Enter on line 158, column 1, the average length of stay (ALOS) for all patients (excluding newborn). This average length of stay is calculated by dividing all patient (census) days from columns 4 and 5, line 150 by total discharges from column 12, line 150. Compute to two decimal places (enter zeros if necessary).

REPORTING REQUIREMENTS

Page 4 PATIENT UTILIZATION STATISTICS ***7020.16b***

This page is required for report periods ending on or after June 30, 2000 and is used to report various patient related statistical information of the hospital, including: licensed beds, available beds, staffed beds, adult and pediatric patient (census) days, number of hospital discharges, ambulatory and ancillary standard units of measure, and other utilization statistics, such as number of Satellite Ambulatory surgeries and number of referred visits. For report periods ending on or before June 29, 2000, see Manual section 7020.16a.

Lines 5 through 155

1. *Insert on line 155, column 1 the number of bassinets at the end of the reporting period. On the remaining lines in column 1, enter the number of licensed beds, at the end of the reporting period by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. Do not include licensed beds placed in suspense. The total licensed beds in column 1, on line 150, must agree with page 1, column 1, line 5.*

2. *Insert on line 155, column 2 the reporting period monthly average number of bassinets. Enter on the remaining lines of column 2 the monthly average number of available beds by discrete Daily Hospital Services cost center as dictated by organizational unit or by beds dedicated for a particular clinical use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total available beds in column 2, on line 150, must agree with page 1, column 1, line 10.*

3. *Insert the reporting period monthly average number of staffed bassinets (set up and staffed for use) on line 155, column 3. Enter the monthly average of staffed (set up and staffed) beds by discrete Daily Hospital Services cost center on lines 5 through 145 as dictated by organizational unit or by beds dedicated for a particular clinic use. If a bed is assigned to more than one cost center, count the bed in the cost center that utilizes it the majority of patient (census) days. The total staffed beds in column 3, line 150, must agree with page 1, column 1, line 15.*

4. *Insert adult patient (census) days in column 4 and pediatric patient (census) days in column 5 by the functional Daily Hospital Services cost center related to the level and type of care the patient is receiving as of the point in time of the hospital daily census tabulation.*

   If a patient is moved from one functional cost center to another, actual patient (census) days spent in each would be reported. If pediatric patients are cared for in a combined adult/pediatric medical/surgical acute unit, the pediatric patient (census) days must be reported in the pediatric acute cost center. GYN patient (census) days are not to be included in the Obstetrics Acute cost center even though the patient may have been housed in that unit. Such patient (census) days must be included in the Medical/ Surgical Acute cost center. Do not enter patient (census) days in the shaded areas.

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NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

5. *Enter in column 11 the number of service discharges by functional Daily Hospital Services cost center for those patients discharged (transferred) from one cost center to another cost center within the hospital. Service discharges are to be counted by the cost center transferring the patient and not by the cost center receiving the patient. Hospital discharges as defined in Section 4120 of the Manual are not included here.*

   When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such transfers are not to be counted as service discharges. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients. Therefore, no service discharges should ever be reported for the nursery cost center.

6. *Enter in column 12 the total number of discharges (including deaths) in the functional Daily Hospital Services cost centers from which the patients were discharged. See Section 4120 of the Manual for the definition of a discharge.*

7. *Total lines 5 through 145, for all the columns, and enter the results on line 150.*

Lines 160 through 215

8. *Enter the total ambulatory units of service, as reclassified, in column 1, lines 160-215. (See Manual Section 2420 for standard units of measure definitions, and Section 4130 for complete definitions of visits.) Enter the inpatient ambulatory units of service in column 7 and outpatient ambulatory units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.*

Lines 230 through 410

9. *Enter total ancillary units of service, as reclassified, in column 1, lines 230 through 410. Enter inpatient ancillary units of service in column 7 and outpatient ancillary units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.*

Lines 505 through 560

10. *Enter the number of surgeries performed at Satellite Ambulatory Surgery Centers during the reporting period on line 505, column 1.*

REPORTING REQUIREMENTS

11. Enter in column 1, line 510 the number of discrete operating rooms existing at Satellite Ambulatory Surgery Centers.

12. Enter the number of surgeries performed in Surgery and Recovery during the reporting period on line 515, column 1.

13. Record the number of surgery minutes related to open heart surgeries on line 520, column 1. See the account description for the Surgery and Recovery cost center in this Manual for the definition of surgery minutes.

14. Insert the number of open heart surgeries performed during the reporting period on line 525, column 1.

15. Enter on line 530, column 1, the number of inpatient or combined inpatient/outpatient operating rooms as of the last day of the reporting period. Do not include operating rooms used exclusively for outpatients.

16. Enter the number of surgeries performed in Ambulatory Surgery Services during the reporting period on line 535, column 1.

17. Enter in column 1, line 540, the number of discrete ambulatory (outpatient) operating rooms used exclusively for outpatients as of the last day of the reporting period.

18. Enter the number of observation care days for patients in organized observation care programs on line 545, column 1. See Section 4130 for the definition of an observation care day.

19. Enter the number of Renal Dialysis Care visits on line 550, column 1. See Section 4130 for the definition of a renal dialysis visit.

20. Enter the number of referred outpatient ancillary services visits on line 555, column 1. See Section 4130 for the definition of a private referred ancillary services outpatient visit.

21. On line 560, column 13, enter the sum of lines 160, 170, 175, 180, 190, 200, 205, 210, 215, 505, 515, 535, 545, 550, and 555. Enter the same total outpatient visits in column 1.

Page 4.2 AMBULATORY, ANCILLARY AND OTHER UTILIZATION STATISTICS 7020.17*a*

This report page is *required for report periods ending on or before June 29, 2000 and is* used to report ambulatory and ancillary standard units of measure and other utilization statistics, such as number of Satellite Ambulatory surgeries and number of referred visits. *For reports ending on or after June 30, 2000, see Manual section 7020.17b.* Ambulatory standard units of measure (units of service) are required to be reported by inpatient and outpatient and by source of payment (Medicare, Medi-Cal, County Indigent Programs, Third-Party, and Other). Ancillary standard units of measure (units of service) are required to be reported by inpatient and outpatient.

REPORTING REQUIREMENTS

NOTE: Hospitals must develop systems to maintain units of service by payor. Allocation of units based on gross revenue is not acceptable. If the hospital is unable to meet this requirement, modifications must be requested from the Office and may be used only after receiving written approval from the Office.

Lines 160-215

1. Enter the total ambulatory units of service, as reclassified, in column 1, lines 160-215. (See Manual Section 2420 for standard units of measure definitions, and Section 4130 for complete definitions of visits.)

2. Report inpatient units of service by payor in columns 2 through 6, and outpatient units of services by payor in column 8 through 12.

3. Enter in column 2 the inpatient units of service related to those patients for which Medicare was the principal payment source.

4. Enter in column 3 the inpatient units of service related to those patients for which Medi-Cal was the principal payment source.

5. Enter in column 4 the inpatient units of service related to those patients for which County Indigent Programs was the principal payment source.

6. Enter in column 5 the inpatient units of service for which a Third-Party other than Medicare, Medi-Cal or County Indigent Programs was the principal payment source.

7. Enter in column 6 the inpatient units of service for which the principal payment course was other than Medicare, Medi-Cal, County Indigent Programs or Third-Party.

8. Enter the total inpatient units of service (sum of columns 2 through 6) in column 7.

9. Enter in column 8 the outpatient units of service related to those patients for which Medicare was the principal payment source.

10. Enter in column 9 the outpatient units of service related to those patients for which Medi-Cal was the principal payment source.

11. Enter in column 10 the outpatient units of service related to those patients for which County Indigent Programs was the principal source of payment.

12. Enter in column 11 the outpatient units of service for which a Third-Party other than Medicare, Medi-Cal or County Indigent Programs was the principal payment source.

REPORTING REQUIREMENTS

13. Enter in column 12 the outpatient units of services for which the principal payment source was other than Medicare, Medi-Cal, County Indigent Programs of Third-Party.

14. The sum of columns 8 through 12 must be added to arrive at column 13. Line by line, the sum of columns 7 and 13 must equal column 1.

Lines 230-410

15. Enter total ancillary units of service, as reclassified, in column 1, lines 230 through 410. Enter inpatient ancillary units of service in column 7 and outpatient ancillary units of service in column 13. The sum of columns 7 and 13, line for line, must equal column 1.

Lines 505 through 560

16. Enter the number of surgeries performed at Satellite Ambulatory Surgery Centers during the reporting period on line 505, column 1 and by principal source of payment in columns 2 through 12. You must report the actual number of surgeries by payor. Do not allocate surgeries based on operating minutes or gross patient revenue.

17. Enter in column 1, line 510 the number of discrete operating rooms existing at Satellite Ambulatory Surgery Centers.

18. Enter the total number of surgeries performed during the reporting period on line 515, column 1. Enter inpatient and outpatient surgeries by principal payment source in columns 2 through 12. You must report the actual number of surgeries by payor. Do not allocate surgeries based on operating minutes or gross patient revenue.

19. Record the number of surgery minutes related to open heart surgeries on line 520, column 1 and by principal source of payment in columns 2 through 6. See the account description for the Surgery and Recovery cost center in this Manual for the definition of surgery minutes.

20. Insert the number of open heart surgeries performed during the reporting period on line 525, column 1 and by principal source of payment in columns 2 through 6.

21. Enter on line 530, column 1, the number of inpatient or combined inpatient/outpatient operating rooms as of the last day of the reporting period. Do not include operating rooms used exclusively for outpatients.

22. Enter the number of surgeries performed in Ambulatory Surgery Services during the reporting period on line 535, column 1 and by patient type and principal source of payment in columns 2 through 12.

REPORTING REQUIREMENTS

23. Enter in column 1, line 540, the number of discrete ambulatory (outpatient) operating rooms used exclusively for outpatients as of the last day of the reporting period.

24. Enter the number of observation care ~~visits~~ *days* for patients in organized observation care programs on line 545, column 1, and by principal source of payment in columns 2 through 12. See Section 4130 for the definition of an observation care ~~visit~~ *day*.

25. Enter the number of Renal Dialysis Care visits on line 550, column 1, and by principal source of payment in columns 8 through 12. See Section 4130 for the definition of a renal dialysis visit.

26. Enter the number of referred outpatient ancillary services visits on line 555, column 1, and by principal source of payment in columns 8 through 12. See Section 4130 for the definition of a private referred ancillary services outpatient visit.

27. On line 560, columns 8 through 13, enter the sum of lines 160, 170, 175, 180, 190, 200, 205, 210, 215, 505, 515, 535, 545, 550, and 555. Total columns 8 through 12, line 560 and enter the resulting total outpatient visits in column 1.

Page 4.1 PATIENT UTILIZATION STATISTICS BY PAYOR *7020.17b*

This page is required for report periods ending on or after June 30, 2000 and is used to report patient related statistics, such as patient (census) days, hospital discharges, and outpatient visits, by payor category for various types of care. For report periods ending on or before June 29, 2000, see Manual section 7020.17a. The payor categories are Medicare - Traditional, Medicare - Managed Care, Medi-Cal -Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors. For payor category descriptions, see Manual sections 2230, and 2430.

NOTE: Report patient (census) days by type of care as of the point in time of the hospital daily census count. Recognizing that nursery patients are neither formally admitted nor discharged, count the day of admission, but not the day of discharge or death. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient or nursery patient (census) day. If a patient is moved from one type of care to another, actual patient (census) days spent in each would be reported.

NOTE: Patient (census) days are the actual days of care rendered during the reporting period. Contrary to Medicare Prospective Payment System requirements, patient (census) days are to include days related to those Medicare patients remaining in the hospital at the end of the reporting period, and are not to include patient (census) days of the prior reporting period for those Medicare patients admitted in the prior period but discharged during the current reporting period.

REPORTING REQUIREMENTS

Lines 5 through 45

1. *Enter the number of Medicare - Traditional patient (census) days in column 1, by type of care, for which Medicare was the principal third party payor during the patients period of hospitalization. Do not include patient (census) days related to Medicare - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

2. *Enter the number of Medicare - Managed Care patient (census) days in column 2, by type of care, for which a managed care plan funded by Medicare was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

3. *Enter the number of Medi-Cal - Traditional patient (census) days in column 3, by type of care, for which Medi-Cal was the principal third party payor during the patients period of hospitalization. Do not include patient (census) days related to Medi-Cal - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

4. *Enter the number of Medi-Cal - Managed Care patient (census) days in column 4, by type of care, for which a managed care plan funded by Medi-Cal was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

5. *Enter in column 5 the number of County Indigent Programs - Traditional patient (census) days , by type of care, for those patients considered to be covered under County Indigent Programs during all or part of the patient's period of hospitalization. Do not include patient (census) days related to County Indigent Programs - Managed Care. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

   A patient under County Indigent Programs - Traditional is a person for whom counties are responsible under Welfare and Institution (W&I) Code Section 17000, including those programs funded in whole or part by County Medical Services Program (CMSP), California Health Care for Indigents Program (CHIP) or Realignment Funds, (or future State subsidy programs) regardless if the hospital renders to the County a bill or other claim for payment.

6. *Enter the number of County Indigent Programs - Managed Care patient (census) days in column 6, by type of care, for those patients covered by a managed care plan funded by a county under County Indigent Programs during all or part of the patient's hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.*

   A patient under County Indigent Programs - Managed Care is a person for whom a county is responsible under Welfare and Institution (W&I) Code Section 17000 and is covered by a managed care plan funded by that county.

REPORTING REQUIREMENTS

7. Enter the number of Other Third Parties - Traditional patient (census) days in column 7, by type of care, for which a third party payor other than Title XVIII (Medicare), Title XIX (Medi-Cal), County Indigent Programs, Other Payors, or managed care plan was the principal payor during the patient's hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

An Other Third Parties - Traditional patient is a patient covered by a private indemnity insurance carrier, Crippled Children's' Services, Workers' Compensation, Tricare (CHAMPUS), Short-Doyle, or California Health and Disability Prevention. Do not include patients covered by a managed care plan.

8. Enter the number of Other Third Parties - Managed Care patient (census) days in column 8, by type of care, for which a managed care plan (Health Maintenance Organizations, Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations, Exclusive Provider Organizations, Exclusive Provider Organizations with Point-of-Service option, etc.) other than one funded by Medicare, Medi-Cal, or a county, was the principal third party payor during the patients period of hospitalization. Enter nursery days on line 40. Enter the number of purchased inpatient days on line 45.

9. Enter the number of Other Indigent patient (census) days in column 9, by type of care, for indigent patients who are not recorded in the County Indigent Programs category and are being provided charity care by the hospital.

10. Enter in column 10 the number of Other Payors patient (census) days for which a payor other than Title XVIII (Medicare), Title XIX (Medi-Cal), County Indigent Program, Other Third-Party, managed care plan, or Other Indigent was the principal payor during the hospitalization.

11. Enter the total patient (census) days, by type of care, in column 11. Line by line, the sum of patient (census) days in columns 1 through 10 must equal column 11. The total patient (census) days in column 11, on line 35, must agree with page 4, sum of columns 4 and 5, line 150.

NOTE: See Manual Section 4120 for the definition of a discharge. When newborn patients must have care beyond that which can be provided in the Nursery, they are transferred to a pediatric unit or a neonatal intensive care unit. Such patients are to be formally discharged from the Nursery cost center and formally admitted as regular hospital patients.

12. Enter in column 12 the total number of Medicare - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

13. Enter in column 13 the total number of Medicare - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

REPORTING REQUIREMENTS

14. Enter in column 14 the total number of Medi-Cal - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

15. Enter in column 15 the total number of Medi-Cal - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

16. Enter in column 16 the total number of County Indigent Programs - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

17. Enter in column 17 the total number of County Indigent Programs - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

18. Enter in column 18 the total number of Other Third Parties - Traditional discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

19. Enter in column 19 the total number of Other Third Parties - Managed Care discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

20. Enter in column 20 the total number of Other Indigent discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

21. Enter in column 21 the total number of Other Payors discharges (including deaths), by type of care. Report nursery discharges on line 40. Report purchased inpatient discharges on line 45.

22. Enter the total discharges, by type of care, in column 22. Line by line, the sum of discharges in columns 12 through 21 must equal column 22. The total discharges in column 22, on line 35, must agree with page 4, column 12, line 150.

Lines 60 through 110

NOTE: See Manual Section 4130 for complete definitions of visits.

23. Enter on line 60, the number of emergency services outpatient visits, including psychiatric emergency room outpatient visits, by principal source of payment in columns 1 through 10.

24. Enter on line 65, the number of clinic outpatient visits, including satellite clinic outpatient visits, by principal source of payment in columns 1 through 10.

25. Enter on line 70, the number of outpatient observation care days by principal source of payment in columns 1 through 10.

REPORTING REQUIREMENTS

26. Enter on line 75, the number of psychiatric day-night care days by principal source of payment in columns 1 through 10.

27. Enter on line 80, the number of home health care outpatient visits by principal source of payment in columns 1 through 10.

28. Enter on line 85, the number of hospice outpatient visits by principal source of payment in columns 1 through 10.

29. Enter on line 90, the sum of satellite ambulatory outpatient surgeries, surgery and recovery outpatient surgeries, and ambulatory outpatient surgeries by principal source of payment in columns 1 through 10.

30. Enter on line 95, the number of private referred outpatient visits by principal source of payment in columns 1 through 10.

31. Enter on line 100, the sum of chemical dependency outpatient visits, adult day health care visits, and renal dialysis outpatient visits by principal source of payment in columns 1 through 10.

32. Enter on line 105, the total outpatient visits (sum of lines 60 through 100) by principal source of payment in columns 1 through 10.

33. Complete column 11 with the total outpatient visits for each type of outpatient visit (sum of columns 1 through 10, lines 60 through 110). Column 11, line 105 must equal the sum of column 11, lines 60 through 100. The total outpatient visits in column 11, on line 105, must agree with page 4, column 13, line 560.

Page 5 BALANCE SHEET - UNRESTRICTED FUND 7020.18

This page is the unrestricted fund balance sheet as of the last day of the reporting period. This page is required for every hospital except certain governmental facilities which operate within the General Fund of the related governmental entity. Remember, DO NOT CHANGE LINE LABELS. Include items which do not fit the line labels on the appropriate "other" lines. Lists of additional detail may be submitted on a separate sheet.

NOTE: All county hospitals operating as a part of the county General Fund must report Property, Plant and Equipment information. Complete lines 80 through 205 of columns 1 and 2 according to Steps 13 through 21 below.

Enter current year data in columns 1 and 3 and prior year data in columns 2 and 4. Effective with reporting periods ending on or after December 31, 1993, prior year data (columns 2 and 4) are optional if the amounts included are the same as reported on the prior year disclosure report (columns 1 and 3). If there has been a restatement or adjustment since the prior report was submitted, the prior year columns must be completed.

REPORTING REQUIREMENTS

Page 0 HOSPITAL GENERAL INFORMATION AND CERTIFICATION 7020.24

This page contains general information about the hospital and those involved in completing the disclosure report. In addition, this page contains a certification statement to be signed by the administrator or other responsible official of the hospital.

1. Enter complete legal name of the hospital in item 1.

2. Enter OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes.

3. Enter in item 3 the name under which the hospital is doing business. If this is the same as the legal name, also enter the legal name here.

4. Enter the hospital's general business phone number in item 4. Enter the area code in the parentheses.

5. If the hospital has a Medi-Cal contract, enter the Medi-Cal contract provider number in item 5 and the contract period in items 27 and 28. This is a nine-place number ~~with~~ *including* a three-letter ~~suffix~~ *prefix and a one letter suffix* (e.g. ~~HCS~~ *HSC*12345F).

6. If the hospital is a Medi-Cal non-contract provider, or is a contract provider but also has certain services which are provided to Medi-Cal patients on a non-contract basis, enter in item 6 the Medi-Cal 9-place provider number with a prefix of ZZT, ZZR, or HSP. This number can be found on the Medi-Cal provider agreement.

7. Enter in item 7 the 6 digit Medicare provider number of the hospital (e.g. XX-XXX).

8. Enter in item 8 the street address of the hospital, in item 9 the city in which the hospital is located, and in item 10 the zip code.

9. If the hospital's mailing address is different from the street address,

   enter that in items 11, 12 and 13. Do not enter the parent company's mailing address.

10. In items 14 and 15 enter the name and title of the chief executive officer. (The person in charge of the day-to-day operations of the hospital.)

11. Enter in items 16 and 17 and 18 the name and complete business phone number and FAX phone number of the person who completed the report and in items 19, 20, 21 and 22 the complete mailing address of that person. The Office will contact this person

REPORTING REQUIREMENTS

REPORTING FORMS ***7030***

The following is a reproduction of the Annual Hospital Disclosure Report.

QUARTERLY REPORTING REQUIREMENTS

PREFACE 8001

Section 443.32 of the Health and Safety Code requires hospitals to report specified summary financial and statistical data. Quarterly financial and utilization reports must be submitted by all hospitals for each calendar quarter beginning on or after January 1, 1986. A form will be mailed to each facility approximately two weeks after the end of each calendar quarter.

Section 90741, Title 22, of the California Code of Regulations, was amended in October 1993 to require all hospitals to submit the Office's Quarterly Financial and Utilization Report in a standard electronic format, as defined by the Office, rather than using hard-copy report forms. ~~Effective with calendar quarters beginning on or after January 1, 1994, quarterly~~ *Quarterly* reports must be prepared using the Office-provided Hospital Quarterly Reporting System (HQRS) software and submitted by modem to the Office's Bulletin Board System (BBS). The HQRS software does not support personal computer (PC) diskette reporting. This means that hospitals must have access to an IBM-compatible PC with a Hayes-compatible modem to submit quarterly reports electronically. *Effective for calendar quarters beginning January 1, 1999, hospitals must have the capability to use the HQRS software running under Windows 95 or later, or Windows NT operating systems.*

Section 97050, Title 22, of the California Code of Regulations allows hospitals to file a request for modification to the Office's electronic quarterly reporting requirements if meeting these requirements is not cost-effective for the hospital. Such requests, if approved, would require the requesting hospital to submit the quarterly reports to the Office on hard-copy report forms.

The quarterly financial and utilization report must be completed and submitted to the Office within 45 days after the end of each calendar quarter. In order to be considered complete, all required items must be completed in accordance with the instructions and shall conform to the uniform description of accounts contained in this Manual. Any hospital which does not file the summary financial and utilization report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, considering all extension days granted by the Office.

Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

All reports must be submitted to the:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
818 K Street, Room 400
Sacramento, CA 95814

This chapter contains a copy of the quarterly report form and instructions.

QUARTERLY REPORTING REQUIREMENTS

11. ~~Hospitals~~ *For quarters ending on or before December 31, 1999, hospitals* that receive the preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans and are operated as units of a coordinated group of health facilities under common management may provide financial data for lines 100 through 185 on a group basis. However, such hospitals are encouraged to report line 100, Total Operating Expenses, for each hospital.

    For quarters beginning on or after January 1, 2000, hospitals that receive the preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans and are operated as units of a coordinated group of health facilities under common management may provide financial data for lines 350 through 850 on a group basis. However, such hospitals are encouraged to report line 830, Total Operating Expenses, for each hospital.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8200

For quarters ending on or before December 31, 1999, complete the Quarterly Financial and Utilization Report following the instructions specified in Instruction No. 1. For quarters beginning on or after January 1, 2000, complete the Quarterly Financial and Utilization Report following the instructions specified in Instruction No. 2.

Instruction No. 1 (Quarters ending on or before December 31, 1999)

1. Enter in item 1 the name under which the hospital is doing business. This may be the hospital's legal name.

2. The HQRS software will enter the OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes.

3. In items 3, 4, and 5, enter the hospital street address, city, and zip code, respectively.

4. Enter in items 6 and 7 the name and complete phone number of the person who completed the report. This person will be contacted by the Office if there are any questions about the report and will be mailed a blank report form for the next reporting period approximately two weeks after the end of the next calendar quarter.

5. Enter in items 8 and 9 the name of the chief executive officer (administrator) and the hospital's main business phone number.

QUARTERLY REPORTING REQUIREMENTS

Instruction No. 2 (Quarters beginning on or after January 1, 2000)

1. *Enter in item 1 the name under which the hospital is doing business. This may be the hospital's legal name.*

2. *The HQRS software will enter the OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes.*

3. *In items 3, 4, and 5, enter the hospital street address, city, and zip code, respectively.*

4. *Enter in items 6 and 7 the name and complete phone number of the person who completed the report. This person will be contacted by the Office if there are any questions about the report and will be mailed a blank report form for the next reporting period approximately two weeks after the end of the next calendar quarter.*

5. *Enter in items 8 and 9 the name of the chief executive officer (administrator) and the hospital's main business phone number.*

6. *Enter in item 10 the complete phone number of the hospital's disaster coordinator. This individual is responsible for coordinating the hospital's disaster preparedness programs.*

7. *The reporting software has been designed for full or partial calendar quarters and for either original or revised data. The HQRS User Guide provides detailed instructions on how to submit full and partial reports.*

   If you have been pre-approved to submit the Office's standard report form, and if the report is for a full calendar quarter, check the appropriate line in column 2 or column 3 for the quarter being reported. Check column 2 if the report is an original report or column 3 if the report is a revised report. Revised reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

   If the report period is for more or less than an actual calendar quarter, enter the beginning date of the reporting period on line 19, column 1, and the ending date of the reporting period on line 20, column 1, and check column 2 or column 3 as appropriate.

8. *For lines 20 through 900, enter the appropriate financial and utilization data pertaining to the quarter being reported.*

QUARTERLY REPORTING REQUIREMENTS

NOTE: If you have been granted permission to file a quarterly report based on your 13-period accounting cycle, be sure that utilization data are also provided for the same reporting period.

9. Enter on line 25 the number of licensed beds (excluding bassinets) stated on the facility license as of the last day of the reporting period. Do not include licensed beds placed in suspense.

10. Enter on line 30 the average number of available beds (excluding bassinets) during the reporting period. Available beds are defined as the daily average complement of beds physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds placed in suspense or in nursing units converted to uses other than inpatient overnight accommodations which cannot be placed back into service within 24 hours.

The number of available beds may be and often is less than the number licensed. On occasion, such as pending license application for a new inpatient service or when placing licensed beds into suspense, the average number of available beds for the reporting period may exceed the number of licensed beds at the end of the reporting period.

11. Enter on line 35 the daily average complement of beds fully staffed (excluding bassinets) during the quarter. Staffed beds are those beds set up, staffed, equipped and in all respects ready for use by patients remaining in the hospital overnight. The number of staffed beds is usually less than the number of available beds, since hospitals typically staff for those beds currently occupied by inpatients, plus an increment for unanticipated admissions.

12. Enter on lines 50 through 95 by payor (Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors) the number of hospital discharges from all Daily Hospital Services cost centers, including Long-Term Care (LTC) patients discharged during the reporting period. The HQRS software will enter on line 100 the sum of lines 50 through 95. These are the total number of discharges as defined in Section 4120 of the Manual. Do not include nursery patients discharged from the nursery.

Discharges are to be reported by primary payor, or that payor who is responsible for the predominant portion of the patient's bill. The primary payor may be different than the expected source of payment at the time of discharge. Do not allocate discharges

QUARTERLY REPORTING REQUIREMENTS

by payor based on the ratio of patient (census) days or gross inpatient revenue.

See Section 4120 of the Manual for more information on the definition of a hospital discharge.

NOTE: Managed care patients are patients enrolled in a managed care plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations, Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations, Exclusive Provider Organizations, Exclusive Provider Organizations with Point-of-Service option , etc.).

The Medicare - Traditional category includes patients covered under the Social Security Amendments of 1965. These patients are primarily the aged and needy.

The Medicare - Managed Care category includes patients covered by a managed care plan funded by Medicare.

The Medi-Cal - Traditional category includes patients who are qualified as needy under state laws.

The Medi-Cal - Managed Care category includes patients covered by a managed care plan funded by Medi-Cal.

The County Indigent Programs - Traditional category includes indigent patients covered under Welfare and Institution Code Section 17000. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources for which the hospital renders a bill or other claim for payment to a county. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

The County Indigent Programs - Managed Care category includes indigent patients covered under Welfare and Institution Code Section 17000 and are covered by a managed care plan funded by a county.

The Other Third Parties - Traditional category includes all other forms of health coverage excluding managed care plans. Examples include Short-Doyle, Tricare (CHAMPUS), IRCA/SLIAG, California Children's Services, indemnity plans, fee-for-service plans, and Workers' Compensation.

QUARTERLY REPORTING REQUIREMENTS

The Other Third Parties - Managed Care category includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county.

The Other Indigent category includes indigent patients, excluding those who are recorded in the County Indigent Programs category and including those who are being provided charity care by the hospital.

The Other Payors category includes all patients who do not belong in the categories listed above, such as those designated as self-pay and U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.

13. *Enter LTC Discharges for the reporting period on line 105. This is an optional item. Hospitals which provide skilled nursing care, intermediate care, transitional inpatient care (SNF Beds), sub-acute care, and other long-term care services are encouraged to report LTC Discharges so that comparable average lengths of stay can be calculated. LTC also includes skilled nursing care provided in swing beds.*

14. *Enter on lines 150 through 195 the number of census patient days by payor for all Daily Hospital Services cost centers, including LTC patient (census) days, for the reporting period. Count the day of formal admission, but not the day of discharge as a patient (census) day. Count as one day, each patient formally admitted and discharged on the same day. Do not include nursery days or purchased inpatient days. Do not allocate patient (census) days by payor based on the ratio of discharges or gross inpatient revenue. On line 200, the HQRS software will enter the sum of lines 150 through 195.*

15. *Enter LTC Patient (Census) Days for the reporting period on line 205. This is an optional item. Hospitals which provide long-term care services, as defined in step 13, and reported LTC Discharges on line 105, are encouraged to report this item.*

16. *Enter on lines 250 through 295 the number of outpatient visits by Section 4130 of the Manual provides detailed definitions for all outpatient visits. Do not include purchased outpatient visits. Please refer to Section 4130 to assure that all outpatient visit information is being properly recorded and reported.*

17. *Enter Gross Inpatient Revenue by payor on lines 350 through 395. These amounts are the total inpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to inpatients during the reporting period. It includes daily hospital services, inpatient ambulatory services, and inpatient ancillary services. The amounts reported*

QUARTERLY REPORTING REQUIREMENTS

by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. The HQRS software will enter the sum of lines 350 through 395 on line .

18. *Enter Gross Outpatient Revenue by payor on lines 450 through 495. These amounts are the total outpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to outpatients during the reporting period. It includes outpatient ambulatory services and outpatient ancillary services. The amounts reported by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. On line 500, the HQRS software will enter the sum of lines 450 through 495.*

19. *Enter the various component amounts of the hospital's Deductions from Revenue for the reporting period on lines 545 through 615. Enter components of deductions from revenue with credit balances as negative amounts (with brackets). Briefly explain in the Comments feature provided by HQRS why a credit balance appears. Complete lines 545 through 615 as follows:*

    a. *Enter Provision for Bad Debts, net of bad debt recoveries, on line 545.*
    b. *Enter Medicare - Traditional contractual adjustments on line 550.*
    c. *Enter Medicare - Managed Care contractual adjustments on line 555.*
    d. *Enter Medi-Cal - Traditional contractual adjustments on line 560.*
    e. *Enter Medi-Cal - Managed Care contractual adjustments on line 565.*
    f. *Enter Disproportionate Share payment adjustments related to Medi-Cal inpatients on line 566. Retroactive Disproportionate Share payments related to prior payment years are to be reported on line 850 as non-operating revenue.*
    g. *Enter County Indigent Programs - Traditional contractual adjustments on line 570.*
    h. *Enter County Indigent Programs - Managed Care contractual adjustments on line 575.*
    i. *Enter Other Third Parties - Traditional contractual adjustments on line 580.*
    j. *Enter Other Third Parties - Managed Care contractual adjustments on line 585. Report capitation premium revenue separately on lines 650 through 680.*
    k. *Enter Charity - Hill-Burton amounts on line 590.*
    l. *Enter Charity - Other amounts on line 595.*
    m. *Enter Restricted Donations and Subsidies for Indigent Care on line 600.*

QUARTERLY REPORTING REQUIREMENTS

County hospitals are to report Realignment Funds that do not relate directly to patient care on line 850, Non-Operating Revenue Net of Non-Operating Expenses. Realignment Funds used for specific patients are to be credited against their accounts receivable. Realignment Funds that are used for direct patient care, but not for specific patients, are to be reported on line 575, County Indigent Programs - Traditional contractual adjustments. In essence, these last two entries reduce the County Indigent Programs - Traditional contractual adjustments account.

o. *U.C. teaching hospitals are to enter Teaching Allowances and Support for Clinical Teaching on lines 605 and 610.*

p. *Enter on line 615 policy discounts, administrative adjustments, and other adjustments and allowances, not specified above.*

The HQRS software will enter the sum of lines 545 through 615 on line 620. This is the sum of all deductions from revenue, net of Disproportionate Share Payments, line 566; Restricted Donations and Subsidies for Indigent Care, line 600; and Support for Clinical Teaching, line 610.

Deductions from revenue must be matched against related gross patient revenue within each quarterly reporting period. Most contractual arrangements with purchasers of health care services allow for the reasonable estimation and recording of deductions from revenue when the contractual purchaser is billed. To record deductions from revenue when claims are paid results in a mismatching of deductions from revenue and gross patient revenue, unless payments for such claims are received within the same reporting period. Prior period cost settlements are to be recorded and reported in the reporting period in which they are paid or received.

Refer to Sections 1400 and 2410.5 of the Manual for more information regarding Charity Care and definitions of the components of deductions from revenue.

20. *Enter Capitation Premium Revenue by payor on lines 650 through 680. The HQRS software will enter the sum of lines 650 through 680 on line 700.*

21. *Enter Net Patient Revenue by payor on lines 750 through 795. Net patient revenue by payor is defined as gross inpatient revenue plus gross outpatient revenue plus capitation premium revenue minus related deductions from revenue. When entering Net Patient Revenue by payor, be sure to apply related bad debts and charity care to that payor category. Enter on line 800 the sum of*

QUARTERLY REPORTING REQUIREMENTS

lines 750 through 795. Total Net Patient Revenue on line 800 must also equal line 400 plus line 500 plus line 700 minus line 620.

22. *Enter Other Operating Revenue on line 810. This amount represents revenue related to health care operations, but not from patient care services. Examples include non-patient food sales, rebates and refunds, purchase discounts, supplies and drugs sold to non-patients, Medical Records abstract sales, and Reinsurance Recoveries. Section 2410.4 of the Manual provides a detailed list and descriptions of Other Operating Revenue accounts.*

23. *Enter Total Operating Expenses on line 830. This amount consists of all operating expenses incurred by the hospital for the reporting period accrued to the end of the reporting period. This includes daily hospital services, ambulatory services, ancillary services, purchased inpatient services, purchased outpatient services, research, education, general services, fiscal services, administrative service, and other unassigned costs. If the physicians' professional component (all amounts paid to hospital-based physicians and residents for patient care) is recorded as an expense, it must be included in this amount. Non-operating expenses and provisions for income taxes are excluded. Do not reduce operating expenses by Other Operating Revenue.*

24. *Line 840, Physicians' Professional Component Expenses, is an optional reporting item. However, hospitals are encouraged to report this amount as it will allow a better indication of the change in Total Operating Expenses. Enter on line 840 the physicians' professional component (PPC) expenses included in the physicians' total compensation. This includes all amounts paid or to be paid to hospital-based physicians and residents for patient care and recorded as an expense of the hospital for the reporting period.*

25. *Enter Non-operating Revenue Net of Non-operating Expenses on line 850. If non-operating expenses are greater than non-operating revenue, enter the amount as a negative number (with brackets). Non-operating items are those revenue and expenses that do not relate directly to the provision of health care services. Examples include gains and losses on the disposal of assets; income, gains and losses from unrestricted investments; revenue and expenses associated with Medical Office Buildings; and various governmental assessments, taxes, and appropriations.*

    See Section 2420.10 of the Manual for a detailed list and descriptions of Non-Operating Revenue and Expense accounts.

26. *On lines 850 through 860, enter the discharges, patient (census) days, and expenses associated with Purchased Inpatient Services.*

QUARTERLY REPORTING REQUIREMENTS

These are optional data items. Purchased Inpatient Services expenses are incurred by the purchasing hospital when inpatient services, including ancillary services, are provided by another hospital for patients who are the responsibility of the purchasing hospital. The patients are not formally admitted as inpatients to the purchasing hospital, but are admitted to the hospital providing the inpatient services. This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the facility purchasing the services. See Section 1250 of the Manual for additional information.

27. *On line 870, enter the outpatient expenses associated with Purchased Outpatient Services. This is an optional item. Purchased Outpatient Services expenses are incurred by the purchasing hospital when outpatient services are provided by another hospital for patients who are the responsibility of the purchasing hospital. The patients are not registered as outpatients of the purchasing hospital, but are registered outpatients of the hospital providing the outpatient services. This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the facility purchasing the services. See Section 1250 of the Manual for additional information.*

28. *Enter the amount of Total Capital Expenditures made during the reporting period on line 880. Capital expenditures are defined as all additions to property, plant and equipment, including amounts which have the effect of increasing the capacity, efficiency, lifespan, or economy of operation of an existing capital asset. These are the expenditures recorded under the property, plant and equipment accounts of the balance sheet, and are subject to depreciation or amortization. (Amounts used for acquiring land for hospital operations must be included here although land does not depreciate.)*

    Be sure to include all capitalized leases and construction- in-progress in addition to purchased property, plant and equipment. Do not reduce capital expenditures to reflect accrued depreciation expense or the disposal of capital assets; or include capital expenditures associated with Medical Office Buildings.

29. *Enter the amount of Fixed Assets Net of Accumulated Depreciation at the end of the reporting period on line 885. Net fixed assets include land, land improvements, buildings and improvements, leasehold improvements, and equipment, less accumulated depreciation and amortization thereon, plus construction-in-progress. Do not include Medical Office Buildings.*

QUARTERLY REPORTING REQUIREMENTS

30. Line 900, Disproportionate Share Funds transferred to Related Public Entity, relate to county, University of California, and district hospitals only and is an optional reporting item. For applicable hospitals, enter on line 900 the amount of disproportionate share funds transferred or to be transferred to the related public entity for the current quarterly period.

31. Enter any comments you may have using the comments feature provided by HQRS, especially if the software has flagged any potential data errors during the validation process, or if there has been a significant change in patient care services since the previously filed report.

Please note that the HQRS software classifies potential data errors as either Fatal, Critical, or Warning; and that Fatal errors must be resolved before a report can be successfully transmitted by modem. We strongly recommend that you print an Edit Report and review any error messages before officially transmitting your report by modem.

32. The Electronic Quarterly Reporting Certification must be completed by an authorized official of the hospital and sent to the Office before the report has been transmitted by modem. The person signing the certification should be aware of the contents of the report and that the certification is being made under penalty of perjury.

Transmit the completed report by modem to the Office's BBS. Consult with the User Guide to make sure your modem is set up properly. If you are unable to transmit your report successfully, check the Troubleshooting Section in the User Guide or with your hospital's Technical Support staff.

33. If you have been granted written permission to file a hard-copy report mail the completed report to:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
818 K Street, Room 400
Sacramento, CA 95814

For your convenience, you may submit your completed and signed quarterly financial and utilization report by telecopier (FAX No. 916-323-7675). You are not required to submit the original report if it has already been sent by telecopier.

APPENDIX B

Licensed Vocational Nurse (LVN) Student Program

An L.V.N. program is for a person in the process of completing a nursing program approved by the Board of Vocational Nurse and Psychiatric Technician Examiners. In such a program 1530 hours of study and concurrent practice are required with clinical supervision done by the program instructor in an affiliated hospital or health facility.

Limited-life asset

Any capital asset, as a building, machine, or patent, the usefulness of which to its owner is restricted by its physical life or by the period during which it contributes to operations.

Liquid asset

Cash in banks and on hand, and other cash assets not set aside for specific purposes other than the payment of a current liability, or a readily marketable investment. The term is somewhat less restrictive than cash asset and much more restrictive than quick asset.

Living trust funds

Funds acquired by an institution subject to agreement whereby resources are made available to the institution on condition that the institution pay periodically to a designated person, or persons, the income earned on the resources acquired for the lifetime of the designated person, or persons, or for a specified period.

Long-term health care facility

Any facility which is separately licensed as an intermediate care or skilled nursing facility.

Maintenance

Effort expended to maintain assets in fit condition to do their work--such items are ordinary and recurring and do not improve the asset or add to its life. A useful distinction between maintenance as preventive and repairs as curative.

Managed Care

When patients are enrolled in a health plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option (POS), etc.).

Proposed Changes to:

1) Hospital Annual Disclosure Report Forms

- Report Pages 3.1 and 3.3, Related Hospital Information
- Report page 4.1, Patient Census Statistics
- Report Page 4.2, Ambulatory, Ancillary, and Other Utilization Statistics
- Report Page 8, Statement of Income - Unrestricted Fund
- Report Page 8.1, Statement of Income - Unrestricted Fund (Non-operating Revenue and Expense)
- Report Page 12, Supplemental Patient Revenue Information
- Report Page 17, Trial Balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers
- Report Page 19a, Cost Allocation - Statistical Basis Short Form
- Report Page 19, Cost Allocation - Statistical Basis
- Report Page 20, Cost Allocation

2) Hospital Financial and Utilization Report Form

Additions are in *italics* and deletions are in ~~strike-out~~ format.